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Medicare & You 2002

2001 Guide to
Health Insurance

Where to Get your Medicare
Questions Answered

Medicare Savings Programs

Health Insurance for Infants,
Children, and Teens

Library Edition

2 0 0 2

Home Health Care

Medicare Preventive Services

www.medicare.gov

New Rules for Switching
Medicare Health Plans

Rights and Protections

Publication Catalog

Resources

PUBS
RA
412
.3
M426
2002



For more publications and information, visit www.medicare.gov or
call 1-800-MEDICARE (1-800-633-4227).



This publication is designed as a special resource for librarians. It puts inside one cover the important information people with Medicare – and those who care about them – need as they make critical decisions about health care.

Refer to www.medicare.gov, the Centers For Medicare & Medicaid Services regularly updated website, for the most current information available, including new editions of publications and updated phone numbers for important contacts. Reproduce this book's resources as needed.

You can also call – or refer patrons to – Medicare's toll-free telephone line, which is open 24 hours a day, seven days a week.



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2002

Medicare & You 2002

This handbook has important information about:

- Your Medicare benefits.
- Choosing a health plan that's right for you.
- New ways to get information.

How do you find what you need? See page 97.



CENTERS FOR MEDICARE & MEDICAID SERVICES

Welcome to *Medicare & You!*

Your Medicare health care coverage is one of the most important assets you have. This handbook is designed to help you learn about the health care choices you have as a person with Medicare. It also tells you about new benefits and new ways to get information.

Fall is the time to look at the Medicare coverage you have and to consider which insurance plan would work best for you. Start with “Section 1: Medicare Basics” to understand Medicare coverage and the types of choices that are important for you to consider. Get the facts you need and make the best choice for you.

We’re making it easier for you to learn about your choices with...

- ✓ **Expanded phone services.** Call 1-800-MEDICARE (1-800-633-4227) for fast answers to your questions. Starting October 1, 2001, you can speak with a customer service representative 24 hours a day, including weekends (see pages 6-7).
- ✓ **Information on the Web.** Look on www.medicare.gov for information you can trust. You can get the most up-to-date Medicare news and answers to your questions right now (see page 8).
- ✓ **New tool to help you decide.** Choosing the Medicare health plan that’s right for you is an important decision. The new “Medicare Personal Plan Finder” can help you make your health plan choice. This new service is on www.medicare.gov on the Web. Or, call 1-800-MEDICARE (1-800-633-4227). Ask about the “Medicare Personal Plan Finder.” Details are on pages 28-29.

No matter which Medicare health plan you pick, you are still in Medicare. You will get all the Medicare services and protections you know and trust.



Tommy G. Thompson
Secretary
Health and Human Services



Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

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What's NEW in Medicare

New coverage for:

- Glaucoma screening, see page 16.
- Clinical trials, see page 21.
- Macular degeneration of the eye (age-related) treatment, see page 15.
- Medical nutrition therapy services, see page 15.

New rules for:

- Joining and leaving Medicare health plans, see pages 49-51.
- People with ALS (Lou Gehrig's Disease), see page 21.
- Immunosuppressive drug coverage, see page 15.

New services:

- 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048) is available 24 hours a day, including weekends starting October, 2001 (see pages 6-7).
- The "Medicare Personal Plan Finder" can help you choose the right health plan (see pages 28-29).

If you have Employer or Union Health Coverage:

Call your employer or union before you make any changes to your health coverage. Your employer or union may offer different plans than those described in this book. See page 57 and questions on pages 19-20, and 22 for important information.

If you are a Railroad Retiree:

Call your local Railroad Retirement Board office for answers to Medicare questions. You can find your local office by calling 1-800-808-0772. More information about Medicare for Railroad Retirees is at www.rrb.gov on the Web.



If your address changes:

Call the Social Security Administration at 1-800-772-1213.

Medicare & You 2002 explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.



Section 1

Medicare Basics

About This Handbook:

- ✓ **Finding Information:** The index starts on page 97. This is an alphabetical list of what is in this handbook, with page numbers.
- ✓ **Words in Blue:** Important words shown in blue are defined on pages 93-96.
- ✓ **Sharing “Medicare & You 2002:”** Households with up to four people with Medicare will get one handbook to share. The handbook will be addressed to one person. This will help save Medicare money. The other people with Medicare in these households will get a postcard. It will tell them how to get an extra handbook if they need it. If your household gets more than one handbook, you can choose to share one copy in the future. If you want to share, call and tell a customer service representative at 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Please have your red, white, and blue Medicare card with you when you call.
- ✓ **Please Keep this Handbook:** This handbook is good (valid) from January 1, 2002 through December 31, 2002. Use it in place of any older version you have now. Keep it where you can find it if you need it.

Did You Know...

...you can get free details about Medicare Health Plans? This information can help you choose the plan that's best for you. It includes a personal listing of plans in your ZIP code. It also has details about plan costs, benefits, and quality. It's important to learn as much as you can before you choose a plan.

To get your free information today, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web.

Section 1

Medicare Basics

Medicare is a health insurance program for:

- People age 65 or older.
- Some people with disabilities under age 65.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Has Two Parts

Part A Hospital Insurance, see pages 11-12.
Most people do not have to pay for Part A.

Part B Medical Insurance, see pages 13-17.
Most people pay monthly for Part B.

Medicare Health Plans

Today's Medicare is about Choice. Your health plan choices include:

The Original Medicare Plan -
Available nationwide.
For more information, see page 31.

or

Medicare + Choice Plans
(pronounced "Medicare plus Choice"),
including:

- Medicare Managed Care plans
(like HMOs, see page 46).
- Medicare Private Fee-for-Service
plans (see page 47).

Available in many areas.

The Medicare health plan that you choose affects many things, like cost, doctor choice, benefits (some have extra benefits, like prescription drugs), convenience, and quality (see pages 26-27).

NEW! For help comparing your health plan choices, use the new "Medicare Personal Plan Finder." See pages 28-29 for details.

Section 1

Medicare Basics

**Need answers and information now?
Medicare is here for you.**

- I'm thinking about joining a Medicare HMO. Which one's best for me?
- I want to buy a Medigap policy. Which one has the extra coverage I need?
- How can I get prescription drug coverage?
- How do I get another Medicare card?
- How do I keep up with what's new in Medicare?
- I can't afford my health care. Can I get help?

Answers to these questions and more are as close as your phone or computer.

- Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) 24 hours a day, including weekends starting October 1, 2001. See pages 6-7 to learn how to use this free service.
- Visit www.medicare.gov on the Web for quick answers to your questions. See page 8 for more details about Medicare's website.
- Read new booklets about Medicare. See pages 9-10 for details about getting free booklets to help you learn more.

Section 1

Medicare Basics

Call 1-800-MEDICARE (1-800-633-4227).

**We're here when you need us,
24 hours a day, including weekends.**

When you call, you will hear:

Thank you for calling 1-800-MEDICARE.

We offer service in English and Spanish.

• For English, press (1). • Para Español, oprima dos (2).

Please listen carefully as our options may change.
Choose from the following **Main Menu** options:

To sign up for
Medicare, change
your address or
replace your
Medicare Card...

Press 1 now

For information
on State
programs that may
help those with
low incomes pay
Medicare
premiums and
copayments...

Press 2 now

To find out how
your doctor or
hospital bill is
paid...

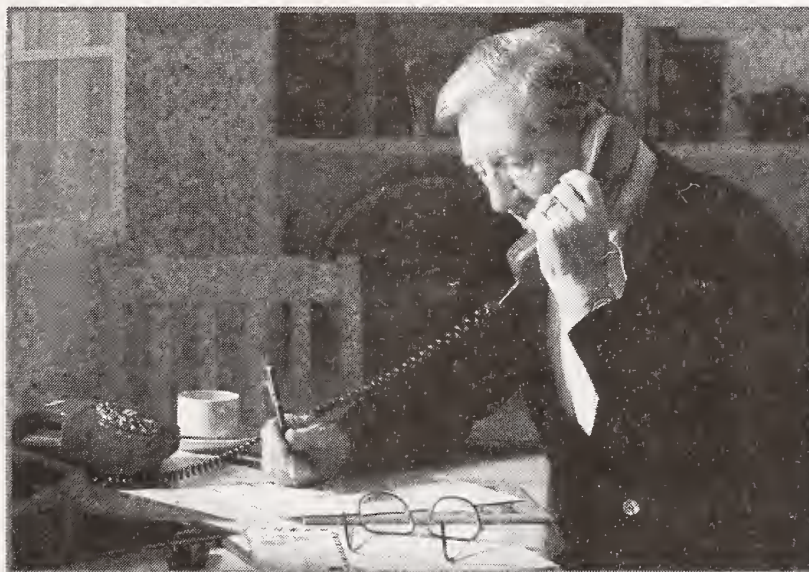
Press 3 now

Tip: You don't have to call for options 1-3. The information is printed on pages 65-92.

Section 1 Medicare Basics

Call 1-800-MEDICARE (1-800-633-4227).

TTY/TDD: 1-877-486-2048 for the hearing and speech impaired.



To order Medicare
publications...

(Please have the
publication
number ready,
see pages 9-10.)

Press 4 now

For answers to
frequently asked
questions,
including information
about Medicare
Health Plan
choices...

Press 5 now

To speak with a
customer service
representative...

Press 0 now

Section 1

Medicare Basics

**Need answers and information now?
Visit our website, www.medicare.gov**

How do I get another Medicare card? I need a copy of a Medicare publication – What's the fastest way to get it? How do I keep up with what's new in Medicare?

Answers to these questions and more are as close as a computer. Go to Medicare's website for quick answers to your questions. The site is updated regularly, so visit often.

★ Publications

Read all of the Medicare publications on your computer or print out a copy to use now.

★ Compare Medicare Health Plans

Find the Medicare health plan that's best for you at "Medicare Health Plan Compare." Compare information about costs, benefits, and quality of care. To shop for health plans, use the new "Medicare Personal Plan Finder" to find the plans that best meet your needs.

★ Compare Nursing Homes

Trying to find a nursing home? Check out "Nursing Home Compare" for details on nursing homes in your area, including state inspection results and nursing staff information. You can get a copy of the Guide to Choosing a Nursing Home and a Nursing Home Checklist to help as you make your decision.

★ Answers to your Questions

Find basic information on Medicare, including coverage, eligibility, enrollment, and answers to frequently-asked questions. Let www.medicare.gov be your first stop for the answers you need now.

★ Look for a Physician

Select the "Participating Physician Directory" for a list of physicians who participate in Medicare. This directory includes physician names, addresses, and specialties.

★ And more...

Medicare's website helps you find the answers you need. See pages 28-29 for more information on our new "Medicare Personal Plan Finder." There's also health information, phone numbers for helpful contacts, details on prescription drug help, and more. Some information is available in Spanish and Chinese.

Section 1

Medicare Basics

Free Booklets About Medicare and Related Topics

Health care decisions are important. Medicare tries to give you information to help you make good decisions. You can order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects. The list below highlights some of the booklets that are available.

How do I get these booklets?

You can:

1. Look at www.medicare.gov on the Web and select “Publications.” You can read, print, or order these booklets. This is the fastest way to get a copy.
2. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and select option “4” to order a free copy of the booklet you want. Have the publication number (listed below) ready when you call. You will get your copy within three weeks.
3. Put your name on the Web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select “Subscribe to Our Mailing List” at the bottom of the page. Then, select the topic “Publications,” type your e-mail address in the box at the bottom, and select “Subscribe.”

What booklets are available?

- 2001 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy (CMS Pub. No. 02110)
- Does Your Doctor or Supplier Accept Assignment? (CMS Pub. No. 10134)
- Guide to Choosing a Nursing Home (CMS Pub. No. 02174)
- NEW!** ■ Health Care Coverage Directory for People with Medicare (CMS Pub. No. 02231)
- Medicare Appeals and Grievances (Complaints) (CMS Pub. No. 10119)

continued on next page

Section 1

Medicare Basics

Free Booklets About Medicare and Related Topics (continued)

- NEW!** ■ Medicare & Clinical Trials (CMS Pub. No. 02226)
- Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Pub. No. 02179)
 - Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (CMS Pub. No. 10128)
 - Medicare Coverage of Skilled Nursing Facility Care (CMS Pub. No. 10153)
 - Medicare Home Health Care (CMS Pub. No. 10969)
 - Medicare Hospice Benefits (CMS Pub. No. 02154)
 - Medicare Preventive Services (CMS Pub. No. 10110)
- NEW!** ■ Medicare Savings Programs (CMS Pub. No. 10126)
- NEW!** ■ New Rules for Switching Medicare Health Plans (CMS Pub. No. 02241)
- Pay it Right! Protecting Medicare from Fraud (CMS Pub. No. 10111)
- NEW!** ■ What Kind of Doctor is a Hospitalist? (CMS Pub. No. 02244)
- NEW!** ■ Where To Get Your Medicare Questions Answered (CMS Pub. No. 02246)
- NEW!** ■ Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam (CMS Pub. No. 02248)
- Your Medicare Benefits (CMS Pub. No. 10116)
- NEW!** ■ Your Medicare Rights and Protections (CMS Pub. No. 10112)

Many of these booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Some booklets are also available in Chinese.

For a catalog of Medicare booklets, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Select option “4” to order a free copy of this catalog (CMS Publication No. 02240).



Section 2

The Medicare Program

Medicare has two parts. Medicare Part A is hospital insurance. Most people do not have to pay for Part A. Medicare Part B is medical insurance. Most people pay monthly for Part B.

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions.

Cost: Most people do not have to pay a monthly payment, called a premium, for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card (see sample card below). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Do you need a new Medicare card?

Look at www.ssa.gov on the Web or call the Social Security Administration at 1-800-772-1213.

| MEDICARE | | HEALTH INSURANCE | |
|--|--|------------------------------|--|
| HEALTH CARE FINANCING ADMINISTRATION | | | |
| NAME OF BENEFICIARY JOHN DOE | | | |
| MEDICARE CLAIM NUMBER 000-00-0000-A | | SEX MALE | |
| IS ENTITLED TO HOSPITAL (PART A) | | EFFECTIVE DATE 07-01-1980 | |
| MEDICAL (PART B) | | 07-01-1980 | |
| SIGN HERE → <u>John Doe</u> | | | |

Section 2

The Medicare Program

Medicare Part A Helps Cover Your:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless medically necessary.

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies, and other services.

Hospice Care: Medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise covered by Medicare. Hospice care is given in your home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed.

Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

Section 2

The Medicare Program

What is Medicare Part B?

* The new Part B premium amount will be available by January 1, 2002. You may be able to get help from your state to pay this premium (see page 58).

Medicare Part B (Medical Insurance) helps cover your doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary (see pages 14-17).

Cost: You pay the Medicare Part B premium of \$50* per month in 2001. This may change January 1, 2002. In some cases, this amount may be higher if you did not sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases (see Q3 on pages 19-20).

Enrolling in (Joining) Part B

Enrolling in Part B is your choice. If you already get Social Security or Railroad Retirement benefits, you are automatically enrolled in Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you are automatically enrolled in Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 65th birthday or your 25th month of disability benefits. If you do not want Medicare Part B, follow the instructions that come with the card.

If you choose to enroll in Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. In these cases, you **won't** get a bill for your premium. If you do not get any of these payments, Medicare sends you a bill for your Part B premium every three months. If you do not get your bill by the 10th of the month, call the Social Security Administration at 1-800-772-1213 or your local Social Security office. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Section 2

The Medicare Program

Enrolling in (Joining) Part B (continued)

If you are close to age 65 and are not yet getting either Social Security or Railroad Retirement benefits or Medicare, you can apply for both at the same time. You can also apply for Medicare only. You can sign up for Part B during your Initial Enrollment Period. Your Initial Enrollment Period begins three months before the month you turn 65 and ends three months after you turn age 65. If you wait until you are 65, or sign up during the last three months of your Initial Enrollment Period, your Medicare Part B start date will be delayed. To apply, you can call or visit your local Social Security office, or call Social Security at 1-800-772-1213. You may be able to apply at www.ssa.gov on the Web if you meet certain rules.

Medicare Part B Helps Cover Your:

Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.

Clinical Laboratory Services: Blood tests, urinalysis, and more.

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies, and other services.

Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.

Blood: Pints of blood you get as an outpatient or as part of a Part B covered service.

Section 2

The Medicare Program

Medicare Also Helps Cover:

- Ambulance services (when other transportation would endanger your health).
- Artificial eyes.
- Artificial limbs that are prosthetic devices, and their replacement parts.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation.
- Emergency care.
- Eyeglasses - one pair of standard frames after cataract surgery with an intraocular lens.
- Immunosuppressive drug therapy for transplant patients as long as you are covered by Medicare (transplant must have been paid for by Medicare).
- Kidney dialysis.
- Macular degeneration of the eye (age-related) treatment, using ocular photodynamic therapy with verteporfin.
- Medical nutrition therapy services for people with diabetes or kidney disease with a doctor's referral.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral drugs for cancer.
- Preventive services (see pages 16-17).
- Prosthetic devices, including breast prosthesis after mastectomy.
- Second opinion by a doctor (in some cases).
- Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners.
- Telemedicine services in some rural areas.
- Therapeutic shoes for people with diabetes (in some cases).
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at approved facilities).
- X-rays, MRIs, CAT scans, EKGs, and some other diagnostic tests.

Section 2

The Medicare Program

Medicare Part B Covered Preventive Services

Bone Mass Measurements:

Frequency of testing varies with your health status.

Who is Covered

Certain people with Medicare at risk for losing bone mass (see Q5 on page 44).

Colorectal Cancer Screening:

Fecal Occult Blood Test - Once every 12 months.

Flexible Sigmoidoscopy - Once every 48 months.

Colonoscopy - Once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.

Barium Enema - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy.

All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy.

Diabetes Services and Supplies:

Coverage for glucose monitors, test strips, and lancets.

Diabetes self-management training.

All people with Medicare who have diabetes (insulin users and non-users).

Certain people with Medicare who are at risk for complications from diabetes, if requested by your doctor or other provider.

Glaucoma Screening:

Once every 12 months, starting January 1, 2002. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.

People with Medicare who are at high risk for glaucoma, including people with diabetes or a family history of glaucoma.

Section 2

The Medicare Program

Medicare Part B Covered Preventive Services

Mammogram Screening:

Once every 12 months.

Medicare also covers new digital technologies for mammogram screening.

Who is Covered

All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.

Pap Test and Pelvic Examination: (Includes a clinical breast exam)

Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.

All women with Medicare.

Prostate Cancer Screening:

Digital Rectal Examination - Once every 12 months.

Prostate Specific Antigen (PSA) Test - Once every 12 months.

All men with Medicare age 50 and older.

Shots (vaccinations):

Flu Shot - Once a year in the fall or winter.

All people with Medicare.

Pneumococcal Pneumonia Shot - One shot may be all you ever need. Ask your doctor.

All people with Medicare.

Hepatitis B Shot

Certain people with Medicare at medium to high risk for Hepatitis B.

Section 2

The Medicare Program

Your Medicare Rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. No matter how you get your Medicare health care, you always have the right to appeal. You may appeal if:

- You don't agree with the amount that is paid.
- A service isn't covered and you think it should be.
- A service is stopped before you think it should be.

You must be given instructions for filing an appeal. These instructions are either on the notice that explains what Medicare pays (see page 37) or in your health plan materials, depending on how you get your Medicare health care. If you decide to file an appeal, ask your doctor or provider for any information that may help your case.

In addition to your appeal rights, you also have certain rights to:

- Information
- Get Emergency Services
- See Doctors, Specialists, including Women's Health Specialists, and Hospitals
- Participate in Treatment Decisions
- Know Your Treatment Choices
- Culturally Competent Services
- File Complaints
- Nondiscrimination
- Privacy of Personal Information
- Privacy of Health Information

You may have additional rights if you are in the hospital or a skilled nursing facility, or if your home health care ends.

For more detailed information about your rights and protections, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Your Medicare Rights and Protections*. Look on page 9 for details about how to get this booklet.

Section 2

The Medicare Program

Common Questions and Answers

Q1: How do I get a new Medicare card if my card is lost, stolen, or damaged?

A: To get a new red, white, and blue Medicare card, call the Social Security Administration (SSA) at 1-800-772-1213. You can also get a new card from SSA at www.ssa.gov on the Web. Select “Medicare information.” SSA will send you a new card. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Q2: When do the Medicare premiums and coinsurance rates change? How will I know what they are?

A: New Medicare premium and coinsurance rates come out each fall and become effective in January. If you get Social Security or Railroad Retirement benefits, new rates are sent to you each year with your cost of living adjustment notice in December. You can also get the new Medicare rates for 2002 after December 1, 2001, by looking at www.medicare.gov on the Web, or by calling 1-800-MEDICARE (1-800-633-4227).

Q3: What if I didn’t sign up for Medicare Part B when I first became eligible?

A: If you didn’t sign up for Medicare Part B when you first became eligible (for example, because you were still working), you may sign up during the General Enrollment Period or the Special Enrollment Period.

1. General Enrollment Period

If you did not take Part B when you were first eligible for Medicare, you may sign up during a General Enrollment Period. This period runs from January 1 through March 31 each year. Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, and you will have to pay this extra amount as long as you have Part B, except in special cases (see page 20).

You can sign up for Part B at your local Social Security office. If you get benefits from the Railroad Retirement Board, you can sign up at your local RRB office. Your Part B coverage will start on July 1 of the year you sign up.

Section 2

The Medicare Program

Q3: What if I didn't sign up for Part B when I first became eligible?
(continued)

A: (continued)

2. Special Enrollment Period

If you didn't enroll in Part B when you were first eligible because you or your spouse were working and had group health coverage through your or your spouse's employer or union, you can sign up for Part B during a Special Enrollment Period.

You can sign up:

- Any time you are still covered by the employer or union group health plan, through your or your spouse's current or active employment, or
- During the 8 months following the month that the employer or union group plan coverage ends, **or** when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible but do not sign up during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period, and the cost of Part B may go up.

For more information about Medicare Part B, or to sign up for it, call the Social Security Administration at 1-800-772-1213, or call your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Section 2

The Medicare Program

Q4: I am under age 65 and have ALS (Amyotrophic Lateral Sclerosis), known as Lou Gehrig's disease. When can I get Medicare?

A: Congress passed a new law. Starting July 1, 2001, if you are under age 65 and have Lou Gehrig's disease (ALS), you get your Medicare benefits either July 1, 2001 or the first month you get disability benefits from Social Security or the Railroad Retirement Board, whichever is later. For more information about disability benefits, look at www.ssa.gov on the Web. Or, call the Social Security Administration at 1-800-772-1213.

Q5: Does Medicare pay for prescription drugs?

A: The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare + Choice plans cover prescription drugs, up to certain dollar limits (sometimes for an extra cost). Some Medigap policies and states also cover prescription drugs. For information about "Prescription Drug Assistance Programs," look at www.medicare.gov on the Web (see page 8). You can use this to learn about different prescription drug coverage options, including Medicare + Choice plans and Medigap policies.

Q6: Does Medicare cover dental services?

A: Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions or dentures. In rare cases, Medicare Part B will pay for certain dental services. In addition, Medicare Part A will pay for certain dental services that you get when you are in the hospital. Call your local Medicare Carrier for more information (see pages 67-72). Some Medicare health plans may offer additional dental coverage.

Q7: Does Medicare cover my costs if I am in a clinical trial?

A: Yes. Medicare pays for routine costs if you take part in an approved clinical trial. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. For more information about clinical trials, get a free copy of *Medicare & Clinical Trials*. Look on page 9 for details about how to get this booklet.

Section 2

The Medicare Program

Q8: What diabetic supplies and services does Medicare cover?

A: Diabetic Supplies: Medicare covers the same supplies for people with diabetes whether or not you use insulin. These include a glucose testing monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions. Medicare also covers therapeutic shoes for people with diabetes. There may be some limits on supplies or how often you get them. For more information about diabetic supplies, call your Durable Medical Equipment Regional Carrier (see page 75).

Diabetic Services: If your doctor thinks you are at risk for complications from diabetes, you are covered for diabetes self-management training. Medical nutrition therapy services are also covered for people with diabetes (or kidney disease) when referred by a doctor. These services can be given by a registered dietician or nutrition professional and include diet counseling and therapy services to help you manage your diabetes. Starting January 1, 2002, Medicare covers glaucoma screening for people with diabetes or a family history of glaucoma. For more information about diabetic services, call your Medicare Carrier (see pages 67-72).

Q9: I have more than one insurance. How do I know who pays first?

A: Sometimes your other insurance pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer. Other insurance that may have to pay first includes: employer group health plan coverage under certain conditions, no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, call the Coordination of Benefits Contractor at 1-800-999-1118 (TTY/TDD: 1-800-318-8782 for the hearing and speech impaired). For more information, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First*. Look on page 9 for details about how to get this booklet.

Section 2

The Medicare Program

Q10: What is a “private contract,” and how does it work?

A: A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. If you sign a private contract with your doctor:

- Medicare won’t pay any amount for the services you get from this doctor.
- You will have to pay whatever this doctor or provider charges you for the services you get. Medicare’s limiting charge will not apply.
- Medicare + Choice plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Your Medigap policy, if you have one, will not pay anything for this service. Call your Medigap insurance company before you get the service if you have any questions.
- Many other insurance plans will not pay for the service either.
- Your doctor must tell you whether Medicare would pay for the service if you get it from another doctor who participates in Medicare.
- Your doctor must tell you if he or she has been excluded from the Medicare program.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract in an emergency or urgent health situation.

You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see pages 73-74).

Section 2

The Medicare Program

Q11: Can I pay for a service myself, even if Medicare covers it?

A: You can always choose to pay out-of-pocket for services that Medicare covers. If you want to pay for the service yourself, ask your doctor not to bill Medicare or any other insurance.

You can always choose to get services not covered under Medicare and pay for these services yourself. In this case, you do not have to sign a private contract, and your doctor does not have to stop giving services through Medicare.

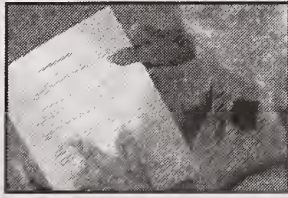
Q12: How is the privacy of my medical records protected?

A: You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under federal and state laws.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or your health plan. This rule will be fully effective on April 14, 2003.

If you have any questions about this privacy rule, look at www.hhs.gov/ocr/hipaa on the Web.

If you are in a Medicare + Choice plan, you also have the right to timely access to your medical records.



Section 3

Introduction to Medicare Health Plans

What are Medicare Health Plans?

Medicare offers you different ways to get your Medicare benefits. These different options are called Medicare health plans. Medicare health plans contract with and are managed by the Medicare program. How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

What types of Medicare health plans are available?

In 2002, Medicare offers the following types of Medicare health plans:

- **The Original Medicare Plan** (sometimes called fee-for-service) - Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplement Insurance) policy to help pay health care costs that this plan does not cover (see page 60).
- **Medicare + Choice (pronounced “Medicare plus Choice”) plans** - Medicare + Choice plans provide care under contract to Medicare. They may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits, such as prescription drugs. There are two types of Medicare + Choice plans. They are available in many parts of the country.

Medicare + Choice plans include:

- **Medicare managed care plans** (like HMOs), and
- **Medicare Private Fee-for-Service plans.**

Section 3

Introduction to Medicare Health Plans

Choosing the Best Medicare Health Plan for You

How you get your Medicare health benefits affects many things. You need to think about things like cost, doctor choice, extra benefits, convenience, and quality when choosing your Medicare health plan. They are all important, but some may be more important to you than others. You need to look at what each plan offers and make the best choice for you.

Your choice will affect:

| | |
|----------------------|--|
| Cost | What will my out-of-pocket costs be? More information about your out-of-pocket costs starts on page 32. |
| Doctor Choice | Can I see the doctor(s) I want to see? |
| Benefits | Do I need extra benefits and services, like prescription drugs, eye exams, hearing aids, or routine physical exams? |
| Convenience | Where are the doctors' offices and what are their hours? What about paperwork? Do I have to file claims myself? Is there a telephone hotline for medical advice from a nurse or other medical staff? |

Quality Data to Help You Choose

Research shows that Medicare health plans differ on quality. The Medicare program measures the quality of care that people like you get. This information is available to everyone. To compare the quality of Medicare health plans in your area, go to www.medicare.gov on the Web and select "Medicare Health Plan Compare." Or, call 1-800-MEDICARE (1-800-633-4227) and ask for health plan quality information.

Section 3

Introduction to Medicare Health Plans

What is important to you?

Think about what is most important to you in a health plan. Then look at this chart. It can help you see which types of plans have the things that are most important to you. The next two sections of this handbook give more details about these types of plans. Using the “Medicare Personal Plan Finder” can help you make your best health plan choice (see pages 28-29).

| | Medicare + Choice Plans | | |
|--|--|---|---|
| | Original Medicare Plan | Managed Care Plan (like an HMO) | Private Fee-for-Service Plan |
| Cost Total Out-of-Pocket Costs | High | Low to Medium | Medium to High |
| Doctor Choice | Widest Choose any doctor or specialist who accepts Medicare. | Some Usually must see a doctor or specialist who belongs to your plan. | Wide Choose any doctor or specialist who accepts the plan's payment. |
| Extra Benefits In addition to Medicare covered benefits. | None | Most Like prescription drugs, eye exams, hearing aids, or routine physical exams. | Some Like foreign travel or extra days in the hospital. |
| Convenience | Varies Available nationwide. | Varies Available in some areas. May require less paperwork and have phone hotline for medical advice. | Varies Available in some areas. May require less paperwork and have phone hotline for medical advice. |

Section 3

Introduction to Medicare Health Plans

NEW this Year! Step-by-Step Help for Choosing a Health Plan

Choosing the right health coverage is an important – but sometimes difficult – decision. The new “Medicare Personal Plan Finder” helps you narrow down your Medicare health plan choices and choose the plan that’s best for you! You can also get important information about special programs that might help you pay health care costs that Medicare doesn’t cover.

You can get this information two ways:

1. Visit www.medicare.gov on the Web for fast results. Select “Medicare Personal Plan Finder.”
2. Call 1-800-MEDICARE (1-800-633-4227). Select option “0.” A customer service representative will help you. You will get your results in the mail within three weeks.

You will be need to answer some simple questions, including:

- What parts of Medicare you have (Part A and/or Part B).
- Your age.
- What your general health is.

If you want information about programs that may help with your health care costs, you will need to answer questions about your income and resources.

Any information you give is always kept private.

“Medicare Personal Plan Finder” Results

When you use the “Medicare Personal Plan Finder,” you will get a personalized summary page (see sample on page 29) with general information to help you compare plans in your area. You can also get detailed information about all the plans available in your area, or just the ones you are most interested in.

Section 3

Introduction to Medicare Health Plans

Sample Summary Page

You may be interested in:

- ☐ State Prescription Drug Assistance Program (1-555-555-5555)
- ☐ "Medicare Basics" Seminar - 9/27/02 (1-555-555-5555)

Below is a summary of the plans that are available in your ZIP code. The out-of-pocket costs column compares average cost for a person of your self-reported age and health status. The chart also includes information on doctor choice, and whether the plan offers any of the following extra benefits: outpatient prescription drugs, routine physical exams, vision services, and dental services.

Original Medicare Plan Only - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately \$xxx each month for beneficiaries.

| Medicare Health Plans | Out-of-Pocket Costs | Doctor Choice (Can you go to any doctor?) | Outpatient Prescription Drugs | Routine Physical Exams | Vision Services | Dental Services |
|-----------------------|---------------------|--|-------------------------------|------------------------|-----------------|-----------------|
| Original Medicare | \$\$\$ | ✓ | | | | |

Original Medicare with a Medigap Plan - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately \$xxx each month for beneficiaries.

| Medicare Health Plans | Out-of-Pocket Costs | Doctor Choice (Can you go to any doctor?) | Outpatient Prescription Drugs | Routine Physical Exams | Vision Services | Dental Services |
|-----------------------|---------------------|--|-------------------------------|------------------------|-----------------|-----------------|
| Medigap Plan C | \$\$\$ | ✓ | | | | |
| Medigap Plan H | \$\$ | ✓ | | | | |

Medicare + Choice Plans - Approximately xx% of people with Medicare have chosen this option. With this option, the Federal Government pays approximately \$xxx each month for beneficiaries.

| Medicare Health Plans | Out-of-Pocket Costs | Doctor Choice (Can you go to any doctor?) | Outpatient Prescription Drugs | Routine Physical Exams | Vision Services | Dental Services |
|-----------------------|---------------------|---|-------------------------------|------------------------|-----------------|-----------------|
| HMO Plan #1 | \$\$ | Usually must see a doctor or specialist who belongs to your plan. | ✓ | ✓ | ✓ | |

Section 3

Introduction to Medicare Health Plans

Whether you get your Medicare health care coverage from the Original Medicare Plan or a Medicare + Choice plan:

You must have Medicare Part A and Part B to enroll in a Medicare + Choice plan.

- You are still in the Medicare program. The Original Medicare Plan and Medicare + Choice plans are all part of the Medicare program.
- You get at least all the Medicare Part A covered services listed on page 12.
- If you pay the monthly Part B premium (\$50 in 2001), you get all the Medicare Part B covered services listed on pages 14-17.
- The Medicare program helps you get quality health care.
- The Medicare program still pays for part of your health care.

What if I have other health insurance or coverage that isn't listed here?

Many people with Medicare also have health coverage in addition to Medicare. You may have or qualify for:

- A Medigap (Medicare Supplement Insurance) policy (see page 60),
- Employer or union health coverage (see page 57),
- Help from your state (see Medicare Savings Programs and Medicaid on pages 58-59),
- TRICARE for Life (for military retirees and their spouses and survivors, see page 58),
- Veterans' benefits (see page 57),
- Other insurance, like long-term care insurance (see page 62).

The way these types of insurance work with Medicare varies. See the page numbers shown above for more information.



Section 4

Original Medicare Plan

What is the Original Medicare Plan?

The Original Medicare Plan is a “fee-for-service” plan. You are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 11). If you are happy getting your health care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice plan.

How does the Original Medicare Plan work?

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- If you have Part A, you get all the Medicare Part A covered services listed on page 12.
- If you pay the monthly Part B premium (\$50 in 2001), you get all the Medicare Part B covered services listed on pages 14-17.
- You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).
- After you get a health care service, you get a Medicare Summary Notice or an Explanation of Medicare Benefits in the mail (see page 37). These notices are sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

**Remember,
words in
blue are
defined on
pages 93-96.**

Section 4

Original Medicare Plan

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on:

- Whether your doctor or supplier agrees to accept assignment (see page 42).
- How often you need health care.
- What type of health care you need.
- Whether you get services or supplies not covered by Medicare.
- Whether you have Part B.

Note: In most cases, you pay for any health care you get while traveling outside of the United States.

The charts on the next few pages show what you pay in the Original Medicare Plan. For details about these covered services, see page 12 for Part A and pages 14-17 for Part B.

To help cover the costs that the Original Medicare Plan does not cover, you can:

- Keep or get employer or union health coverage (see page 57), or
- Buy a Medigap (Medicare Supplement Insurance) policy (see page 60), or
- Check if you can get help from your state (see pages 58-59).

Section 4

Original Medicare Plan

Medicare Part A (Hospital Insurance) Helps Pay For:

What YOU Pay in 2001 in the Original Medicare Plan (see note on page 34)

(For more information on coverage, see page 12.)

Hospital Stays

For each benefit period YOU pay:

- A total of \$792 for a hospital stay of 1-60 days.
- \$198 per day for days 61-90 of a hospital stay.
- \$396 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 94.)
- All costs for each day beyond 150 days.

Skilled Nursing Facility (SNF) Care

Look on page 9 for details about how to get a free booklet for more information.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to \$99 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary (see pages 76-80).

Home Health Care

Look on page 9 for details about how to get a free booklet for more information.

YOU pay:

- Nothing for home health care services.
- 20% of the Medicare-approved amount for durable medical equipment.

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see pages 81-82).

Hospice Care

Look on page 9 for details about how to get a free booklet for more information.

YOU pay a copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest). The amount you pay for respite care can change each year.

If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see pages 81-82).

Blood

YOU pay for the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

Section 4

Original Medicare Plan

Medicare Part B (Medical Insurance) Helps Pay For:

What YOU Pay in 2001 in the Original Medicare Plan (see Note below)
(For more information on coverage, see pages 14-17.)

Medical and Other Services

Each year YOU pay:

- \$100 deductible (once per calendar year).
- 20% of Medicare-approved amount after the deductible (see “assignment” on page 42).
- 20% for all outpatient physical, occupational, and speech-language therapy services.
- 50% for outpatient mental health care. (See Q1 on page 43.)

Clinical Laboratory Services

YOU pay nothing for Medicare-approved services.

Home Health Care

Look on page 9 for details about how to get a free booklet for more information.

YOU pay:

- Nothing for Medicare-approved services.
- 20% of the Medicare-approved amount for durable medical equipment.

If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see pages 81-82).

Outpatient Hospital Services

YOU pay a coinsurance or copayment amount, which may vary according to the service. Look on page 9 for details about how to get a free booklet for more information.

Blood

YOU pay for the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

Note: New Medicare Part A and B amounts will be available by January 1, 2002. Actual amounts you must pay may be higher if the doctor or supplier does not accept assignment, **and you may have to pay the entire charge at the time of service.** Medicare will then send you its share of the charge (see page 42).

If you have general questions about Medicare Part B, call your Medicare Carrier (see pages 67-72). If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (see page 75).

Section 4

Original Medicare Plan

Medicare Part B Covered Preventive Services

What YOU pay in the Original Medicare Plan
(For more information on coverage, see pages 16-17.)

Bone Mass Measurements

20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

Colorectal Cancer Screening

Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.

Diabetes Services and Supplies

20% of the Medicare-approved amount after the yearly Part B deductible.

Glaucoma Screening

20% of the Medicare-approved amount after the yearly Part B deductible.

Mammogram Screening

20% of the Medicare-approved amount with no Part B deductible.

Pap Test and Pelvic Examination (includes a clinical breast exam)

Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.

Prostate Cancer Screening

Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA (Prostate Specific Antigen) Test.

Shots (vaccinations)

Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment (see page 42). For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

Section 4

Original Medicare Plan

What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Health care costs not covered by Medicare will include, but are not limited to:

- Acupuncture.
- Deductibles, coinsurance, or copayments when you get health care services (see the “What YOU Pay” part of the charts on pages 33-35).
- Dental care and dentures (in most cases).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams.
- Orthopedic shoes.
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see page 15).
- Routine or yearly physical exams.
- Screening tests except those listed on pages 16-17.
- Shots (vaccinations) except those listed on page 17.

To help cover the costs the Original Medicare Plan does not cover, see page 32.

Section 4

Original Medicare Plan

How are my bills paid in the Original Medicare Plan?

For Part A Services and some Part B Services:

The provider of the covered service sends a claim to your Fiscal Intermediary.

For Part B Services and Supplies:

The provider of the covered service or supply sends a claim to your Medicare Carrier, or your Durable Medical Equipment Regional Carrier.

You get a Medicare Summary Notice (MSN) or an Explanation of Medicare Benefits (EOMB). Soon, everyone will get MSNs as EOMBs are phased out. The MSN lists all the services or supplies that were billed to Medicare for that month. Check this notice to be sure you got all the services, medical supplies, or equipment that providers billed to Medicare.

If you have questions about your bills, see pages 67-80 for important phone numbers.

- Questions about the charges? Call the provider of the service or supply.
- Disagree with what was paid? You can appeal (see page 18).
- Think the provider is being dishonest? Call the company that sent you the notice. Their phone number is on the notice.

Note: You should not need to file any Medicare claims. Providers and suppliers are required by law to file Medicare claims for the covered services and supplies you get. If your doctor or supplier does not file the Medicare claim in a timely manner, contact your Medicare Carrier.

How do I read the Medicare Summary Notice (MSN)?

Pages 38-39 have a sample MSN for Part B services, followed by information on how to read it. You could also get an MSN for Part A services and for durable medical equipment. Remember that the MSN is not a bill. DO NOT send money to Medicare or to the provider until you get a bill.

Section 4

Original Medicare Plan



Medicare Summary Notice

June 16, 2002

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

3 Your Medicare Number: 111-11-1111A

If you have questions, write or call:

Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Phone number: (XXX) XXX-XXXX
1-800-XXX-XXXX

TTY for Hearing Impaired: 1-800-XXX-XXXX

5
HELP STOP FRAUD: Protect your Medicare Number as you would a credit card number.

6 This is a summary of claims processed from 5/15/02 through 6/15/02.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

| Dates of Service | Services Provided | Amount Charged | Medicare Approved | Medicare Paid Provider | You May Be Billed | See Notes Section |
|---|-------------------|----------------------|----------------------|------------------------|----------------------|-------------------|
| Claim number 12345-84956-84556 | | 8 | | | | 14 |
| Doctor name, Street Address, City, State ZIP Code | 15 | 10 \$55.00 | 11 \$44.35 | 12 \$0.00 | 13 \$44.35 | a b |
| 03/07/02 1 Office/Outpatient Visit, ES (99214) | 9 | | | | | |

7 THIS IS NOT A BILL - Keep this notice for your records.

See the next page for the rest of the Medicare Summary Notice.

See pages 40-41 for an explanation of the numbered items.

Section 4

Original Medicare Plan

Notes Section:

16

- a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.
- b This approved amount has been applied toward your deductible.

Deductible Information:

17

You have now met \$44.35 of your \$100 Part B deductible for 2002.

General Information:

18

Please notify us if your address has changed or is incorrect as shown on this notice.

Appeals Information - Part B

19

If you disagree with any claims decision on this notice, you can request an appeal by December 16, 2002.

Follow the instructions below:

- 1) Circle the item(s) you disagree with and explain why you disagree.
- 2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.
- 3) Sign here _____ Phone Number (____) _____

See pages 40-41 for an explanation of the numbered items.

Section 4

Original Medicare Plan

Explanation of numbered items on Medicare Summary Notice (MSN)

1. The **Date** the MSN was sent.
2. The **Customer Service Information** box. Write or call using the information in this box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.
3. Your **Medicare Number**. It should match the number on your Medicare card.
4. Your **Name and Address**. If these are incorrect on your MSN, please contact both the company shown in the customer service information section and the Social Security Administration immediately.
5. Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.
6. **Part B Medical Insurance - Assigned Claims/Unassigned Claims**. This line describes the category of services received. It tells you if it is a Medicare Part A or B service or durable medical equipment. See the back of your MSN for an explanation of Medicare assignment.
7. **Dates of Service**. This shows when your doctor or supplier provided the service(s) listed. You may use these dates to compare with the dates shown on your doctor or supplier bill.
8. Each claim is assigned a **Claim Number**, which you may be asked to provide when calling regarding your MSN.
9. **Services Provided** is a brief description of the service or supply, the number of services and the service code.
10. **Amount Charged** is the charge submitted to Medicare by the provider of service(s).
11. **Medicare Approved** is the amount Medicare approved for the service(s) you received.

Section 4

Original Medicare Plan

12. **Medicare Paid Provider.** In most situations, Medicare pays 80 percent of the approved amount after subtracting any unmet portion of the yearly deductible. For unassigned service(s), this column is titled Medicare Paid You.
13. **You May Be Billed.** This is the total amount the provider is allowed to bill you. It combines the deductibles, the coinsurance and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount. There may be other laws in your state that limit doctors' charges.
14. **See Notes Section.** If a letter appears in this column, refer to the Notes Section. Please see item 16.
15. **Provider's Name and Address.** More than one name may be shown. If you were treated by a clinic or group medical practice, the clinic or group name will be shown, followed by the name of the doctor who performed the service. If the service was ordered or referred by another doctor, the referring doctor's name may also be listed. The address shown is the billing address which may be different from where you received the service(s).
16. The **Notes Section** gives more detailed information about your claim.
17. The **Deductible Information** section shows how much of your yearly deductible has been met.
18. The **General Information** section provides important Medicare news and information.
19. **Appeals Information**, such as how and when to request an appeal, is shown here. See the back of your MSN for more information and how to get help with appeal requests.

Section 4

Original Medicare Plan

What is “assignment” in the Original Medicare Plan and why is it important?

Assignment is an agreement between Medicare, and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full for Part B services and supplies. You pay the coinsurance and deductible amounts. In some cases (such as if you have both Medicare and Medicaid), your health care providers and suppliers must accept assignment.

Look at www.medicare.gov on the Web to find doctors in your area who always accept assignment. Select “Participating Physician Directory.”

If assignment is not accepted, charges are often higher. This means you may pay more. In addition, you may have to pay the entire charge at the time of service. Medicare will then send you its share of the charge.

There is a limit on the amount your doctors and providers can bill you. The highest amount of money you can be charged for a covered service by doctors and other health care providers who don’t accept assignment is called the **limiting charge**. The limit is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

For more information about assignment, get a free copy of *Does Your Doctor or Supplier Accept Assignment?* Look on page 9 for details about how to get this booklet.

Section 4

Original Medicare Plan

Common Questions and Answers

- Q1:** Does the Original Medicare Plan cover mental health care?
- A:** Yes. If you are in the Original Medicare Plan, Part A covers inpatient mental health care, including room, meals, nursing, and other related services and supplies. Part B covers mental health services generally given outside a hospital, including visits with a doctor, clinical psychologist, clinical social worker, and lab tests. For certain outpatient mental health services, Medicare payment is reduced. For more information about Medicare coverage for mental health care, get a free copy of *Medicare and Your Mental Health Benefits*. Look on page 9 for details about how to get this booklet.
- Q2:** Does the Original Medicare Plan pay for care in a nursing home?
- A:** Usually, no. Most nursing home care is custodial care (help with bathing, dressing, using the bathroom, and eating). This care is not covered by Medicare. Medicare Part A only covers skilled care given in a certified skilled nursing facility. You must meet certain conditions and coverage is limited. For more information about Medicare skilled nursing care, get a free copy of *Medicare Coverage of Skilled Nursing Facility Care*. Look on page 9 for details about how to get this booklet.
- Q3:** Does the Original Medicare Plan cover me when I travel outside of the United States?
- A:** The Original Medicare Plan does not cover health care when you travel outside the United States, except for some emergency situations in Mexico and Canada. Some Medigap policies do cover care outside the United States (see page 60). Check your insurance coverage before you travel outside the country.

Section 4

Original Medicare Plan

Q4: Why are some of my bills for outpatient services higher than they were before July 2000?

A: Medicare changed the way it pays for outpatient services in July 2000. Depending on which services you get and the hospital where you get these services, your out-of-pocket costs may be different than they were before, for the same service. For more information about this new payment system, get a free copy of *Your Guide to the Outpatient Prospective Payment System*. Look on page 9 for details about how to get this booklet.

Q5: Why didn't Medicare pay for my bone mass measurement? I thought this service was covered.

A: Medicare covers bone mass measurement for "certain people with Medicare who are at risk for losing bone mass."

These people are at risk of losing bone mass:

- A woman who is estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and findings (as determined by the doctor or a qualified non-physician practitioner), or
- A person with vertebral abnormalities seen on x-ray and that shows osteoporosis, osteopenia (low bone mass), or vertebral fracture, or
- A person getting (or expecting to get) glucocorticoid (steroid) therapy that is equal to at least 7.5 mg of prednisone per day, for more than three months, or
- A person with primary hyperparathyroidism, or
- A person being monitored to see how well an FDA-approved osteoporosis drug therapy is working.



Section 5

Medicare + Choice Plans

What is a Medicare + Choice plan?

Medicare + Choice plans provide care under contract to Medicare. They may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits.

Medicare + Choice plans currently include:

- Medicare managed care plans (like HMOs), and
- Medicare Private Fee-for-Service plans.

Medicare + Choice plans are available in many areas of the country. For information about the Medicare + Choice plans available in your area, look at www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227).

**Remember,
words in
blue are
defined on
pages 93-96.**

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice plan manages the Medicare coverage for its members. If Medicare + Choice plans are available in your area, you can join one and get your Medicare covered benefits. By joining a Medicare + Choice plan, you can often get extra benefits, like prescription drugs. The Medicare + Choice plan may have additional rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

If you join a Medicare + Choice plan:

- You are still in the Medicare program.
- You must have Medicare Part A **and** Part B, and continue to pay the monthly Medicare Part B premium (\$50 in 2001). If you are already in a Medicare managed care plan and have only Part B, you may stay in your plan.
- You still get all your regular Medicare-covered services (see pages 12-17). You may be able to get extra benefits like prescription drugs or additional days in the hospital.
- You have Medicare rights to protect you (see page 18).

Section 5

Medicare + Choice Plans

How does a Medicare managed care plan work?

- In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Call the plan you are interested in to see which doctors are in the plan.
- Doctors can join or leave managed care plans at any time. If your doctor leaves your plan, ask your plan for the names of other plan doctors in your area.
- Generally, you need a referral to see a specialist (like a cardiologist), which means your primary care doctor tells you and the specialist it is OK for you to go.
- You may pay more if you get health care outside the service area of the plan, unless you have an emergency or need urgent care (see Q7 and Q8 on page 55). The service area is where the plan accepts members and where you get services from the plan.
- Each year, the companies offering Medicare + Choice plans can decide to join, stay with, or leave Medicare.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not a part of the plan. Most of the time this costs you more, but this option gives you more choices.
- Exceptions to these rules might apply in emergencies or certain cases when care is urgently needed (see Q7 and Q8 on page 55).

Section 5

Medicare + Choice Plans

How does a Private Fee-for-Service Plan work?

- The private company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.
- You can go to any doctor or hospital that accepts the terms of the plan's payment.
- The private company provides health care coverage to people with Medicare who join this plan. The private company pays a fee for each doctor visit or service you get, and you may also pay a fee.
- The private company may have a "pre-notification" requirement. For example, it may require that you tell the plan of any planned inpatient hospital stays.
- You may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services. If this is allowed, there may be a limit to what they can charge, and you must pay the difference.

Your costs in a Medicare + Choice plan

What you pay out-of-pocket depends on:

- Whether the plan charges a monthly premium in addition to your monthly Part B premium of \$50 in 2001.
- How much you pay for each visit or service ("copayments").
- The type of health care you need and how often you get it.
- The types of extra benefits you use, and whether the plan covers them.

Section 5

Medicare + Choice Plans

Joining a Medicare + Choice plan

Who can join a Medicare + Choice plan?

Note: If you are already in a Medicare managed care plan and have only Part B, you may stay in your plan.

If you have Medicare, you can join a Medicare + Choice plan if:

- You have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- You live in the service area of the plan. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare managed care plan, it's also where you get services from the plan. The plan can give you more information about its service areas.
- You do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Special Rules for People with End-Stage Renal Disease:

If you have End-Stage Renal Disease (ESRD), you usually cannot join a Medicare + Choice plan. However, if you are already in a plan, you can stay in the plan you are in or join another plan offered by the same company in the same state. If you've had a successful kidney transplant, you may be able to join a plan.

Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare + Choice plans.

If you have ESRD and are in a Medicare + Choice plan, and the plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare + Choice plan if one is available in your area. This is true for people whose plans left Medicare or stopped providing coverage in their area on or after December 31, 1998.

Section 5

Medicare + Choice Plans

Joining a Medicare + Choice plan (continued)

When can I join one of these plans?

There are three main times when you can join. They are:

1. When you first become eligible for Medicare.
2. November. Medicare + Choice plans must accept new members from November 1 through November 30 of each year. In 2001, Medicare + Choice plans must also accept new members in December. In most cases, if you join a Medicare health plan in November (or December 2001), your coverage begins on January 1 of the next year.
3. January 1 through June 30, 2002 (if a plan is accepting new members).

Note: Some Medicare + Choice plans limit the number of members in their plans. These plans may not accept new members all of the time. A plan can tell you if it is signing up new members.

How do I join a Medicare + Choice plan?

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, or
2. Get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative.

You will get a letter from the plan telling you when your coverage begins.

Caution: You can't join more than one Medicare health plan at the same time. If you try to join more than one Medicare health plan with the same starting dates, you may end up enrolled in the plan you didn't want to be in.

Section 5

Medicare + Choice Plans

Joining a Medicare + Choice plan (continued)

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare + Choice plan?

Yes, you can keep it. However, it may cost you a lot and you may get little benefit from it while you are in a Medicare + Choice plan.

If you drop your Medigap policy, you may not be able to get it back, except in certain situations. If you join a Medicare + Choice plan when you first become eligible for Medicare at age 65, or if this is the first time you've enrolled in a Medicare + Choice plan, you may have special Medigap protections that give you another chance to buy a Medigap policy. For more information on Medigap policies and protections, get a free copy of the *Guide to Health Insurance For People with Medicare: Choosing a Medigap Policy*. Look on page 9 for details about how to get this booklet.

How can I tell if I am in a Medicare + Choice plan?

If you joined a Medicare + Choice plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in a Medicare + Choice plan, you can call the number listed on your membership card. You can also call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772. Ask the customer service representative to check if you are in a Medicare + Choice plan.

Section 5

Medicare + Choice Plans

Leaving a Medicare + Choice plan

When can I leave a Medicare + Choice plan?

Starting January 1, 2002, you can leave a Medicare + Choice plan and join another plan only one time from January 1 through June 30, 2002. After you have made one change (including changing to the Original Medicare Plan), you must stay in that plan for the rest of the year.

Example: Mrs. Smith belongs to the Alpha managed care plan. She leaves the Alpha managed care plan in May 2002 to join the Beta managed care plan. She now must stay with the Beta plan for the rest of the year.

For more information on leaving a Medicare + Choice plan, get a free copy of *New Rules for Switching Medicare Health Plans*. Look on page 9 for details about how to get this booklet.

How do I leave a Medicare + Choice plan?

Write to the plan or to the Social Security Administration, or call 1-800-MEDICARE (1-800-633-4227). Tell them you want to leave the plan. The plan should send you a letter with the date your plan coverage ends. If you don't get a letter, call the plan and ask for the date. When you leave a plan, you are automatically returned to the Original Medicare Plan, unless you join another Medicare + Choice plan. If you join another Medicare + Choice plan, you should get a letter telling you when your coverage starts. You will be disenrolled from your old plan automatically.

What if I move out of the plan's service area?

You will need to call the health plan to see if you can stay in the plan if you move out of the plan's service area. If you must leave the plan, you must disenroll. If there are no Medicare + Choice plans available in your new location, you will be covered by the Original Medicare Plan. You can choose to join another Medicare + Choice plan, if one is available in your new area and they are accepting new members. Or, you can choose the Original Medicare Plan.

Section 5

Medicare + Choice Plans

For more information about Medicare + Choice plans:

Look at www.medicare.gov on the Web. Select “Medicare Health Plan Compare” or “Publications” to look at or print plan information or booklets.

Or, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can get:

- A free copy of detailed health plan information for Medicare health plans in your ZIP code. This information includes health plan names, contact phone numbers, costs, extra benefits, quality ratings, and disenrollment information to help you compare health plans.
- A free copy of *Your Guide to Private Fee-for-Service Plans* (CMS Pub. No. 10144).

Section 5

Medicare + Choice Plans

Common Questions and Answers

Q1: How do I find out if my doctor or hospital belongs to a plan?

A: If you want to keep seeing your doctor when you join a Medicare + Choice plan, call and ask if he or she is in the Medicare + Choice plan and would continue to see you if you joined the plan. You can also get a list from your plan of doctors and hospitals that belong to the plan.

Q2: Can I join a Medicare + Choice plan if I have employer or union coverage?

A: If you join a Medicare + Choice plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare health plan coverage. Talk to your employer's or union's benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to get it back.

Q3: Do Medicare + Choice plans cover me when I travel outside the United States?

A: Some Medicare + Choice plans cover you when you travel outside of the United States. Check with your plan before you leave the country.

Q4: Is mental health care covered in a Medicare + Choice plan?

A: If you are in a Medicare + Choice plan, read your plan materials or call the plan to learn about its coverage of mental health care. You must get at least the same coverage as provided by Medicare Part A and Medicare Part B of the Original Medicare Plan.

Section 5

Medicare + Choice Plans

Q5: Who decides where Medicare + Choice plans will be available?

A: Medicare + Choice plans are offered by private companies. A company can decide that a plan will be available to everyone with Medicare in a state, or be open only in certain counties. A company may also choose to offer more than one plan in an area, with different benefits and costs. Each year, companies offering Medicare + Choice plans can decide to stay in or leave Medicare.

Companies may decide to offer plans in your area in the future. For the most up-to-date information about Medicare + Choice plans in your area, look at www.medicare.gov on the Web. Select “Medicare Health Plan Compare.” Or, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Q6: How long do Medicare + Choice plans contract with Medicare?

A: When a Medicare + Choice plan decides to contract with (join or stay in Medicare), it agrees to stay for the entire year, January 1 through December 31. Private companies offer Medicare + Choice plans. Each year, they make a business decision to stay in or leave the Medicare program. Costs and extra benefits can also change each year.

Section 5

Medicare + Choice Plans

Q7: What is a “medical emergency”?

How do I get emergency care in a Medicare + Choice plan?

A: A medical emergency is when you believe that your health is in serious danger — when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse.

All Medicare + Choice plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need to get permission from a primary care doctor first. Your plan must pay for emergency care (you may have to pay a copayment). If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency care, you have the right to appeal (see Q9 on page 56).

Q8: What is “urgently needed care”?

How do I get urgent care in a Medicare + Choice plan?

A: Urgently needed care is care you need for a sudden illness or injury that is not a medical emergency.

In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are in the U.S. but out of the plan’s service area and cannot wait until you return home, your plan must pay for urgently needed care (you will have to pay a copayment). If it does not, you have the right to appeal (see Q9 on page 56).

In a Private Fee-for-Service plan, you can get urgently needed care from any doctor who accepts the terms of the plan’s payment.

Section 5

Medicare + Choice Plans

Q9: Can I appeal my Medicare + Choice plan's payment decisions?

A: Yes. You have the right to a fair, efficient, and timely process for resolving issues related to your health plan's payment of a service or product. This process is called an appeal.

Your plan must tell you in writing how to appeal a plan decision. You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. After you file an appeal, the plan will review its decision. If waiting for a decision will harm your health, the plan must answer you within 72 hours. If your plan does not decide in your favor, it will send your appeal to an independent review organization. See your plan's membership materials for details about your appeal rights. You have a right to ask your plan for a copy of your file. It contains your medical and other information about your appeal.

Q10: What can I do if my Medicare + Choice plan doesn't stay in the Medicare program?

A: If your Medicare + Choice plan leaves the Medicare program, you will be sent a notification letter. The letter will tell you if there are other Medicare + Choice plans in your area that you can join. You can always choose the Original Medicare Plan. You will be automatically returned to the Original Medicare Plan if you don't choose another Medicare + Choice plan. You may be able to buy a Medigap policy (see page 60). You should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare-covered services.



Section 6

Other Insurance and Ways to Pay Health Care Costs

Do you know what health care insurance you have and what it helps pay for? Now is a good time to review your coverage. Medicare may not be the only health care coverage you have or can get. You might be able to get more health care coverage, help to lower your out-of-pocket costs, or more benefits than you get with Medicare alone.

Whether or not you can get employer, union, military, or other health care coverage, you should learn about all of the different kinds of health care coverage. What coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you.

For more information about how these kinds of insurance work with Medicare, get a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First*. Look on page 9 for details about how to get this booklet.

1.

Employer or Union Health Coverage

Call the benefits administrator at your or your spouse's current or former employer or union. Ask if you have or can get health care coverage based on your or your spouse's past or current employment.

When you have retiree coverage from an employer or union, they manage this coverage. They may change the benefits or premiums, and may also cancel the coverage if they choose.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your employer's or union's benefits administrator.

2.

Veterans' Benefits

If you are a Veteran, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about Veterans' benefits and services available in your area.

Section 6

Other Insurance and Ways to Pay Health Care Costs

3.

Military Retiree Benefits

TRICARE for Life (TFL) starts October 1, 2001. It provides expanded medical coverage for: Medicare-eligible retirees, including retired guard members and reservists; Medicare-eligible family members and widow/widowers; and certain former spouses if they were eligible for TRICARE before age 65. You must have Medicare Part B to be eligible for TFL.

If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. If you use a Medicare provider, Medicare will be the first payer for all Medicare-covered services, and TFL will be the second payer. TFL will pay all Medicare copayments and deductibles and cover most of the costs of certain care not covered by Medicare.

For more information on TFL, call 1-888-DOD-LIFE (1-888-363-5433) or look at www.TRICARE.osd.mil on the Web. Call 1-800-538-9552 for other military retiree benefit questions.

4.

Medicare Savings Programs (Help From Your State)

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay some or all of Medicare's premiums. Some programs may also pay Medicare deductibles and coinsurance.

You can apply for these programs if:

- You have Medicare Part A. (If you have Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.)
- and
- You are an individual with resources of \$4,000 or less, or are a couple with resources of \$6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds,

Section 6

Other Insurance and Ways to Pay Health Care Costs

4.

Medicare Savings Programs (continued)

and

- You are an individual with a monthly income of less than \$1,273,* or are a couple with a monthly income of less than \$1,714.*

Call your state medical assistance office (see pages 90-91) and ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

- * Income limits will change slightly in 2002. If you live in Alaska or Hawaii, income limits are slightly higher.

5.

Medicaid

If your income and assets are even more limited than those described above, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and you qualify for Medicaid. Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for nursing home care and outpatient prescription drugs that are not covered by Medicare. For more information about Medicaid, call your state medical assistance office (see pages 90-91).

6.

Prescription Drug Assistance Programs

There are programs that may offer you discounts or free medication. For more information, look at www.medicare.gov on the Web. Select "Prescription Drug Assistance Programs." If you don't have a computer, your local senior center or library may be able to help you get this information. Or, call 1-800-MEDICARE (1-800-633-4227) and ask for information about these programs.

Section 6

Other Insurance and Ways to Pay Health Care Costs

7.

Medigap (Medicare Supplement Insurance) Policies

A Medigap policy is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage. Medigap policies must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies so you can compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a “Medicare SELECT” policy. Medicare SELECT policies usually cost less because you must use specific hospitals and, in some cases, doctors to get insurance benefits from the policy. In an emergency, you may use any doctor or hospital.

For more information about Medigap policies, costs and choices, call 1-800-MEDICARE (1-800-633-4227) and speak with a customer service representative.

Do I need to buy a Medigap policy?

Medigap policies help pay health care costs only if you have the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare + Choice plan.

You do not need to buy a Medigap policy if you are in a Medicare + Choice plan. In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in one of these health plans. If you have Medicaid, it is generally illegal for an insurance company to sell you a Medigap policy.

Section 6

Other Insurance and Ways to Pay Health Care Costs

When is the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period. It starts on the first day of the month in which you are both age 65 or older and are enrolled in Medicare Part B. Your Medigap open enrollment period lasts for 6 months. Once the 6-month Medigap open enrollment period starts, it cannot be changed.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of your past or present health problems. They must also shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have.

Important: If you don't buy a Medigap policy during your open enrollment period, you may not be able to buy the one you want, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back.

Note: If you are age 65 or older and have health coverage through an employer or union based on your or your spouse's current or active employment, you may want to wait to enroll in Medicare Part B and delay your Medigap open enrollment period.

For information about buying a Medigap policy, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*. Look on page 9 for details about how to get this booklet.

Section 6

Other Insurance and Ways to Pay Health Care Costs

8.

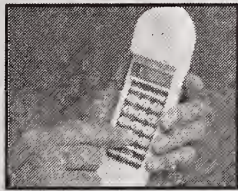
Long-Term Care Insurance

Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare does not pay for long-term care.

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see pages 88-89) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

Insure Kids Now

Free or low-cost health insurance is available now in your state for uninsured children under age 19. Call 1-877-KIDS-NOW (1-877-543-7669) toll-free for more information.



Section 7

Information For Your Local Area

Local Medicare Health Plan Information

Starting October 1, 2001, comprehensive information about the Medicare health plans in your area is available through 1-800-MEDICARE (1-800-633-4227). Customer service representatives are available 24 hours a day, including weekends, to help with general questions about Medicare, and about Medigap policies, Prescription Drug Assistance Programs and Medicare + Choice plan options in your area.

The customer service representative can mail you detailed information about the Medicare health plans in your area, including:

- Phone numbers, addresses and websites of each local plan
- Monthly premium charged
- Benefits and costs, including extra benefits like prescription drugs
- Plan quality and member satisfaction ratings
- Disenrollment information

The customer service representative can help you narrow down your Medicare health plan choices using a new “Medicare Personal Plan Finder.” This tool is designed to help you focus on the issues most important to you when making a decision about the health plan that is right for you. The customer service representative will mail your personalized results from this tool within three weeks of your call. See pages 28-29 for more information about the “Medicare Personal Plan Finder.” See pages 6-7 for complete information about 1-800-MEDICARE (1-800-633-4227).

You can also look at www.medicare.gov on the Web to get all local plan information and use the “Medicare Personal Plan Finder.” See page 8 for more details about what’s available on www.medicare.gov on the Web. These services provide more information than was included in previous versions of the *Medicare & You* handbook.

Section 7

Information for Your Local Area

Where to Call for Help (Local Phone Numbers)

In the blue-tabbed section, you will find phone numbers to call for help with your Medicare questions. These phone numbers were correct at the time of printing. Sometimes phone numbers change. You can find the most up-to-date phone numbers by looking at www.medicare.gov on the Web. Select “Helpful Contacts.” Or, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).



Moving?

To change your address, call the Social Security Administration at 1-800-772-1213.

Section 7

Information for Your Local Area

Where do I call for help with my Medicare questions?

| If you have questions about: | Call: | See page: |
|------------------------------------|---|-----------|
| Address changes | Social Security Administration | 66 |
| Appeals (how to file) | State Health Insurance Assistance Program | 73-74 |
| Complaints (quality of care) | Peer Review Organization | 83-87 |
| Death notification | Social Security Administration | 66 |
| Discrimination | Office for Civil Rights | 92 |
| Enrolling in Medicare | Social Security Administration | 66 |
| Fraud | | |
| Part A | Fiscal Intermediary | 76-80 |
| Part B | Medicare Carrier | 67-72 |
| Help paying health care costs | State Medical Assistance Office | 90-91 |
| Long-term care insurance | State Health Insurance Assistance Program | 73-74 |
| Medicare card (replacement) | Social Security Administration | 66 |
| Medicare health plan choices | State Health Insurance Assistance Program | 73-74 |
| Medicare Part A bills and services | Fiscal Intermediary | 76-80 |
| Medicare Part B bills and services | Medicare Carrier | 67-72 |
| Medicare rights and protections | State Health Insurance Assistance Program | 73-74 |
| Medigap policies | State Insurance Department | 88-89 |
| Railroad Retirement benefits | Railroad Retirement Board | 66 |
| Social Security benefits | Social Security Administration | 66 |

If you are in a Medicare+Choice plan, call your plan with questions about bills, health services, and appeals.

Section 7

Information for Your Local Area

Note: At the time of printing, phone numbers listed were correct. To get the most up-to-date phone numbers, look at www.medicare.gov on the Web and select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

1-800-MEDICARE

Call about:

- General Medicare information
- Information about Medicare health plans
- Ordering Medicare booklets
- TTY/TDD and local phone numbers
- Information on Medigap and Prescription Drug Assistance Programs

1-800-MEDICARE

1-800-633-4227

TTY/TDD: 1-877-486-2048

All States

Coordination of Benefits Contractor

Call about:

- General questions about Medicare Secondary Payer
- General questions about who pays first

1-800-999-1118

All States

Department of Health and Human Services Office of the Inspector General

Call about:

- Reporting fraud and abuse in any federal health care program

1-800-447-8477

TTY/TDD: 1-800-377-4950

All States

Railroad Retirement Board

Call about:

- Signing up for Medicare Part A and Part B, lost RRB Medicare (**RRB Beneficiaries Only**) card, address change
- Part B bills and services (Palmetto GBA 1-800-833-4455)
- Part A bills and services (see Fiscal Intermediary on pages 76-80)

1-800-808-0772

Social Security Administration

Call about:

- Changing your address
- Lost Medicare card
- Enrolling in Medicare Part A and Part B
- Medicare premium problems

1-800-772-1213

TTY/TDD: 1-800-325-0778

All States

Department of Veterans Affairs

Call about:

- Medical benefits

1-800-827-1000

All States

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Alabama

Blue Cross Blue Shield of
Alabama,
1(800)292-8855
TTY/TDD: 1(800)548-2546

Arizona

Noridian Mutual Insurance
Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Colorado

Noridian Mutual Insurance
Company,
1(800)332-6681
TTY/TDD: 1(888)552-9336

Alaska

Noridian Mutual Insurance
Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Arkansas

Blue Cross Blue Shield of
Arkansas,
1(800)482-5525
TTY/TDD: 1(888)476-3009

Connecticut

First Coast Service Options,
1(800)982-6819
TTY/TDD: 1(866)359-3614

American Samoa

Noridian Mutual Insurance
Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

California

National Heritage Insurance
Company,
1(800)952-8627
TTY/TDD: 1(530)634-7538
Note: (In Southern CA call
1-800-675-2266)

Delaware

Trailblazer Health
Enterprises also includes
Northern VA (counties of
Arlington & Fairfax),
1(800)444-4606
TTY/TDD: 1(800)516-6684

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Florida

First Coast Service Options,
1(800)333-7586
TTY/TDD: 1(800)754-7820

Hawaii

Noridian Mutual Insurance
Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Indiana

AdminaStar Federal,
1(800)622-4792
TTY/TDD: 1(317)841-4677

Georgia

Cahaba Government Benefit
Administrators,
1(800)727-0827
TTY/TDD: 1(800)255-0056

Idaho

Cigna Medicare,
1(800)627-2782
TTY/TDD: 1(800)686-5485

Iowa

Noridian Mutual Insurance
Company,
1(800)532-1285
TTY/TDD: 1(800)735-2943

Guam

Noridian Mutual Insurance
Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Illinois

Wisconsin Physicians
Service,
1(800)642-6930
TTY/TDD: 1(800)535-6152

Kansas

Blue Cross Blue Shield of
Kansas,
1(800)432-3531
TTY/TDD: 1(800)430-8757

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Kentucky

AdminaStar Federal,
1(800)999-7608
TTY/TDD: 1(317)841-4677

Maryland

Trailblazer Health
Enterprises also includes
Northern VA (counties of
Arlington & Fairfax),
1(800)444-4606
TTY/TDD: 1(800)516-6684

Minnesota

Wisconsin Physician
Services,
1(800)352-2762
TTY/TDD: 1(800)828-2837

Louisiana

Louisiana Medicare - Part B,
1(800)462-9666
TTY/TDD: 1(225)231-2292

Massachusetts

National Heritage Insurance
Company,
1(800)882-1228
TTY/TDD: 1(800)559-0443

Mississippi

Cahaba Government
Benefits Administrators,
1(800)682-5417
TTY/TDD: 1(601)977-5820

Maine

National Heritage Insurance
Company,
1(800)492-0919
TTY/TDD: 1(800)668-1339

Michigan

Wisconsin Physicians
Service,
1(800)482-4045
TTY/TDD: 1(800)535-6152

Missouri

Blue Cross Blue Shield of
Arkansas Eastern Missouri,
1(800)392-3070
TTY/TDD: 1(877)645-9577
Blue Cross Blue Shield of
Kansas Kansas City Area,
1(800)892-5900
TTY/TDD: 1(800)430-8757



PHONE NUMBERS

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

| | | |
|---|---|---|
| Montana Blue Cross Blue Shield of Montana, 1(800)332-6146 TTY/TDD: 1(800)238-5086 | New Hampshire National Heritage Insurance Company, 1(800)447-1142 TTY/TDD: 1(800)668-1339 | New York HealthNow of Western New York Services upstate NY, 1(800)252-6550 TTY/TDD: 1(607)766-6260 Empire Medicare Services Services downstate NY, 1(800)442-8430 TTY/TDD: 1(877)623-6190 Group Health Inc. (GHI Medicare) Queens county only, 1(800)632-5572 TTY/TDD: 1(646)458-6794 |
| Nebraska Blue Cross Blue Shield of Kansas, 1(800)633-1113 TTY/TDD: 1(800)430-8757 | New Jersey Empire Medicare Services, 1(800)462-9306 TTY/TDD: 1(800)992-0165 | North Carolina Cigna Medicare, 1(800)672-3071 TTY/TDD: 1(800)686-5517 |
| Nevada Noridian Mutual Insurance Company, 1(800)444-4606 TTY/TDD: 1(888)552-9336 | New Mexico Blue Cross Blue Shield of Arkansas, 1(800)423-2925 TTY/TDD: 1(800)822-9472 | North Dakota Noridian Mutual Insurance Company, 1(800)247-2267 TTY/TDD: 1(888)552-9336 |

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Northern Mariana Islands

Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Rhode Island

Blue Cross Blue Shield Of Rhode Island,
1(800)662-5170
TTY/TDD: 1(888)239-3356

Ohio

Nationwide Mutual Insurance Company,
1(800)282-0530
TTY/TDD: 1(800)542-5250

South Carolina

Palmetto Government Benefits
Administrator,
1(800)583-2236
TTY/TDD: 1(877)566-3572

Oklahoma

Blue Cross Blue Shield of Arkansas,
1(800)522-9079
TTY/TDD: 1(800)822-9472

South Dakota

Noridian Mutual Insurance Company,
1(800)437-4762
TTY/TDD: 1(888)552-9336

Oregon

Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Tennessee

Cigna Medicare,
1(800)342-8900
TTY/TDD: 1(800)686-5485

Pennsylvania

HGS Administrators,
1(800)382-1274
TTY/TDD: 1(800)242-8471

Texas

Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

Puerto Rico

Triple S, Inc.,
1(800)981-7015 in-state calls only
TTY/TDD: 1(787)782-5430

Utah

Regence Blue Cross Blue Shield of Utah,
1(800)426-3477
TTY/TDD: 1(800)346-4128

Section 7

Information for Your Local Area

Medicare Carrier: Call about questions on Medicare Part B coverage, bills and medical services, or for information on how to recognize Medicare fraud and abuse. If you get benefits from the Railroad Retirement Board, see page 24.

Vermont

National Heritage Insurance Company,
1(800)447-1142
TTY/TDD: 1(800)668-1339

West Virginia

Nationwide Mutual Insurance Company,
1(800)848-0106
TTY/TDD: 1(800)542-5250

Virgin Islands

Triple S, Inc.,
1(800)474-7448 in-state calls only

Wisconsin

Wisconsin Physicians Service,
1(800)944-0051
TTY/TDD: 1(800)828-2837

Virginia

Trailblazer Health Enterprises (Rest of State),
1(800)552-3423
TTY/TDD: 1(800)618-4666

Wyoming

Noridian Mutual Insurance Company,
1(800)442-2371
TTY/TDD: 1(888)552-9336

Washington

Noridian Mutual Insurance Company,
1(800)444-4606
TTY/TDD: 1(888)552-9336

Washington D.C.

Trailblazer Health Enterprises also includes Northern VA (counties of Arlington & Fairfax),
1(800)444-4606
TTY/TDD: 1(800)516-6684

Section 7

Information for Your Local Area

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

Alabama

1(800)243-5463

Alaska

1(800)478-6065 in-state calls only

American Samoa

1(888)875-9229

Arizona

1(800)432-4040

Arkansas

1(800)224-6330

California

1(800)434-0222

Colorado

1(888)696-7213

Connecticut

1(800)994-9422 in-state calls only

Delaware

1(800)336-9500 in-state calls only

Florida

1(800)963-5337

Georgia

1(800)669-8387

Guam

1(888)875-9229

Hawaii

1(888)875-9229

Idaho

1(800)247-4422 in-state calls only

Illinois

1(800)548-9034 in-state calls only

Indiana

1(800)452-4800 in-state calls only

Iowa

1(800)351-4664

Kansas

1(800)860-5260 in-state calls only

Kentucky

1(877)293-7447 in-state calls only

Louisiana

1(800)259-5301 in-state calls only

Maine

1(800)750-5353 in-state calls only

Maryland

1(800)243-3425 in-state calls only

Massachusetts

1(800)882-2003 in-state calls only

Michigan

1(800)803-7174

Minnesota

1(800)333-2433

Mississippi

1(800)948-3090

Missouri

1(800)390-3330

Montana

1(800)332-2272 in-state calls only

Section 7

Information for Your Local Area

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

Nebraska

1(800)234-7119

Nevada

1(800)307-4444

New Hampshire

1(800)852-3388 in-state calls only

New Jersey

1(800)792-8820 in-state calls only

New Mexico

1(800)432-2080 in-state calls only

New York

1(800)333-4114

North Carolina

1(800)443-9354 in-state calls only

North Dakota

1(800)247-0560

Northern Mariana Islands

1(888)875-9229

Ohio

1(800)686-1578

Oklahoma

1(800)763-2828 in-state calls only

Oregon

1(800)722-4134 in-state calls only

Pennsylvania

1(800)783-7067

Puerto Rico

1(877)725-4300 in-state calls only

Rhode Island

1(401)222-2880

South Carolina

1(800)868-9095 in-state calls only

South Dakota

1(800)822-8804 in-state calls only

Tennessee

1(800)525-2816

Texas

1(800)252-9240

Utah

1(800)541-7735 in-state calls only

Vermont

1(800)642-5119 in-state calls only

Virgin Islands

1(340)772-7368

Virginia

1(800)552-3402

Washington

1(800)397-4422

Washington D.C.

1(202)739-0668

West Virginia

1(877)987-4463

Wisconsin

1(800)242-1060

Wyoming

1(800)856-4398

Section 7

Information for Your Local Area

Durable Medical Equipment Regional Carrier (DMERC): Call about bills for durable medical equipment and a list of approved suppliers of this equipment.

If you live in:

Your DMERC is:

Illinois
Indiana
Maryland
Michigan
Minnesota
Ohio
Virginia
Washington D.C.
West Virginia
Wisconsin

Administar Federal
1(800)270-2313
TTY/TDD:
1(317)841-4677

If you live in:

Your DMERC is:

Alaska
American Samoa
Arizona
California
Guam
Hawaii
Idaho
Iowa
Kansas
Missouri
Montana
Nebraska
Nevada
North Dakota

Northern Mariana Islands
Oregon
South Dakota
Utah
Washington
Wyoming

Cigna Medicare
1(800)899-7095
TTY/TDD:
1(800)970-7494

If you live in:

Your DMERC is:

Connecticut
Delaware
Maine
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont

Health Now of
New York, Inc.,
Region A
1(800)842-2052
TTY/TDD:
1(800)842-9519

If you live in:

Your DMERC is:

Alabama
Arkansas
Colorado
Florida
Georgia
Kentucky
Louisiana
Mississippi
New Mexico
North Carolina
Oklahoma
Puerto Rico
South Carolina
Tennessee
Texas
Virgin Islands

Palmetto
Government
Benefits
Administration
1(800)583-2236
TTY/TDD:
1(800)788-5414

Section 7

Information for Your Local Area

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

| | | |
|---|---|--|
| Alabama Blue Cross Blue Shield of Alabama, 1(800)292-8855 TTY/TDD: 1(800)548-2547 | Arkansas Blue Cross Blue Shield of Arkansas, 1(877)356-2368 TTY/TDD: 1(888)476-3009 | Delaware Empire Medicare Services, 1(800)442-8430 TTY/TDD: 1(877)623-6190 |
| Alaska Premera Blue Cross Medicare, 1(877)602-7896 | California United Government Services, 1(866)804-0684 | Florida First Coast Service Options, Inc., 1(800)333-7586 TTY/TDD: 1(800)754-7820 Note: Medicare Part A - press #2 |
| American Samoa United Government Services, 1(866)264-4990 | Colorado Trailblazer Health Enterprises, 1(800)442-2620 TTY/TDD: 1(800)516-6684 | Georgia Blue Cross Blue Shield of Georgia, 1(800)322-3380 TTY/TDD: 1(706)571-5454 |
| Arizona Blue Cross Blue Shield of Arizona, 1(877)602-7909 TTY/TDD: 1(602)864-4823 | Connecticut Empire Medicare Services, 1(800)442-8430 TTY/TDD: 1(877)623-6190 | Guam United Government Services, 1(866)264-4990 |

Section 7

Information for Your Local Area

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

| | | |
|---|---|--|
| Hawaii United Government Services, 1(866)264-4990 | Iowa Cahaba Health Benefits Administrators, 1(877)910-8139 | Maine Associated Hospital Services, 1(888)896-4997 TTY/TDD: 1(207)822-4646 |
| Idaho Medicare Northwest, 1(866)804-0681 TTY/TDD: 1(503)276-1899 | Kansas Blue Cross Blue Shield of Kansas, 1(800)445-7170 TTY/TDD: 1(800)430-8757 | Maryland Care First Blue Cross Blue Shield Maryland, Medicare Part A, 1(800)655-1636 |
| Illinois Anthem Insurance Companies, 1(877)602-2426 TTY/TDD: 1(866)737-8930 | Kentucky Anthem Insurance Companies, 1(800)999-7608 TTY/TDD: 1(866)284-0881 | Massachusetts Associated Hospital Services, 1(888)896-4997 TTY/TDD: 1(207)822-4646 |
| Indiana Anthem Insurance Companies, 1(800)622-4792 TTY/TDD: 1(317)841-4677 | Louisiana Trispan Health Services, 1(800)932-7644 TTY/TDD: 1(601)939-5704 | Michigan United Government Services, 1(866)804-0686 |



PHONE NUMBERS

Section 7

Information for Your Local Area

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

Minnesota

Noridian Mutual Insurance Company,
1(800)330-5935
TTY/TDD: 1(888)552-9336

Nebraska

Blue Cross Blue Shield of Nebraska,
1(877)602-7775

New Mexico

Trailblazer Health Enterprises,
1(800)442-2620
TTY/TDD: 1(800)516-6684

Mississippi

Trispan Health Services,
1(800)932-7644
TTY/TDD: 1(601)939-5704

Nevada

Mutual of Omaha,
1(877)647-6528

New York

Empire Medicare Services,
1(800)442-8430
TTY/TDD: 1(877)623-6190

Missouri

Mutual of Omaha,
1(877)647-6528

New Hampshire

Anthem Health Plans of New Hampshire-Vermont,
1(800)522-8323
TTY/TDD: 1(800)499-2865

North Carolina

Blue Cross Blue Shield of North Carolina,
1(800)685-1512
TTY/TDD: 1(800)735-2962

Montana

Blue Cross Blue Shield of Montana,
1(800)447-7828x4086
TTY/TDD: 1(800)637-8010

New Jersey

Riverbend Government Benefits Administrators,
1(866)641-2007

North Dakota

Noridian Mutual Insurance Company,
1(888)241-1051
TTY/TDD: 1(888)552-9336



PHONE NUMBERS

Section 7

Information for Your Local Area

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

| | | |
|---|--|---|
| Northern Mariana Islands United Government Services, 1(866)264-4990 | Pennsylvania Veritus Medicare Services, 1(800)853-1419 TTY/TDD: 1(800)452-8086 | South Dakota Cahaba Health Benefits Administrators, 1(877)910-8139 |
| Ohio Anthem Insurance Companies, 1(877)602-2430 TTY/TDD: 1(866)737-8930 | Puerto Rico Cooperativa De Seguros De Vida, 1(866)863-8598 | Tennessee Riverbend Government Benefit Administrators, 1(866)641-2007 TTY/TDD: 1(423)763-3088 |
| Oklahoma Group Health Service of Oklahoma, 1(877)910-8153 | Rhode Island Blue Cross Blue Shield of Rhode Island, 1(800)662-5170 TTY/TDD: 1(888)239-3356 | Texas Trailblazer Health Enterprises, 1(800)442-2620 TTY/TDD: 1(800)516-6684 |
| Oregon Medicare Northwest, 1(866)804-0681 TTY/TDD: 1(503)276-1899 | South Carolina Palmetto Government Benefits Administrators, 1(800)583-2236 TTY/TDD: 1(803)935-0147 | Utah Regence Blue Cross Blue Shield of Utah, 1(877)602-8817 TTY/TDD: 1(800)346-4128 |



PHONE NUMBERS

Section 7

Information for Your Local Area

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse. Calls may be referred to another company that covers your claims.

Vermont

Anthem Health Plans of
New Hampshire-Vermont,
1(800)522-8323
TTY/TDD: 1(800)499-2865

Washington

Premiera Blue Cross
Medicare,
1(877)602-7896

Wisconsin

United Government
Services,
1(800)531-9695
TTY/TDD: 1(800)722-8140

Virgin Islands

Cooperativa De Seguros De
Vida,
1(866)863-8598

Washington D.C.

Care First Blue Cross Blue
Shield Maryland, Medicare
Part A,
1(800)655-1636

Wyoming

Blue Cross Blue Shield of
Wyoming,
1(888)557-2301

Virginia

United Government
Services,
1(877)768-5471

West Virginia

United Government
Services,
1(877)768-5471

Section 7

Information for Your Local Area

Regional Home Health Intermediary (RHHI): Call about questions on home health care, hospice care, and fraud and abuse.

If you live in:

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Your RHHI is:

Associated
Hospital Service
of Maine
1(888)896-4997
TTY/TDD:
1(207)822-4646

If you live in:

Colorado
Delaware
Iowa
Kansas
Maryland
Missouri
Montana
Nebraska
North Dakota
Pennsylvania
South Dakota
Utah
Virginia
Washington D.C.
West Virginia
Wyoming

Your RHHI is:

Cahaba Health
Benefits
Administration
1(877)910-8139

If you live in:

Alabama
Arkansas
Florida
Georgia
Illinois
Indiana
Kentucky
Louisiana
Mississippi
New Mexico
North Carolina
Ohio
Oklahoma
South Carolina
Tennessee
Texas

Your RHHI is:

Palmetto
Government
Benefits
Administration
1(800)583-2236

If you live in:

Michigan
Minnesota
New Jersey
New York
Puerto Rico
Virgin Islands
Wisconsin

Your RHHI is:

United Government
Services
1(800)531-9695
TTY/TDD:
1(800)722-8140

Section 7

Information for Your Local Area

Regional Home Health Intermediary (RHHI): Call about questions on home health care, hospice care, and fraud and abuse.

If you live in:

Your RHHI is:

If you live in:

Your RHHI is:

Hawaii

United Government
Services
1(866)264-4990

Alaska

American Samoa

Arizona

California

Guam

Idaho

Nevada

**Northern Mariana
Islands**

Oregon

Washington

United Government
Services

1(877)602-7904

Section 7

Information for Your Local Area

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

| | | |
|--|---|--|
| Alabama Alabama Quality Assurance Foundation, 1(800)760-3540 | Arkansas Arkansas Foundation for Medical Care, Inc., 1(800)272-5528 | Delaware Quality Insights of Delaware, 1(800)422-8804 in-state calls only |
| Alaska PRO West, 1(800)445-6941 TTY/TDD: 1(800)251-8890 | California CMRI, 1(800)841-1602 TTY/TDD: 1(800)881-5980 | Florida Florida Medical Quality Assurance, Inc., 1(800)844-0795 |
| American Samoa Mountain Pacific Quality Health Foundation, 1(800)524-6550 | Colorado Colorado Foundation for Medical Care, Inc., 1(800)727-7086 TTY/TDD: 1(303)695-3314 | Georgia Georgia Medical Care Foundation, 1(800)979-7217 |
| Arizona Health Services Advisory Group, Inc., 1(800)359-9909 | Connecticut Qualidigm, 1(800)553-7590 | Guam Mountain Pacific Quality Health Foundation, 1(800)524-6550 |

Section 7

Information for Your Local Area

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

| | | |
|---|---|---|
| Hawaii Mountain Pacific Quality Health Foundation, 1(800)524-6550 | Iowa Iowa Foundation for Medical Care, Inc., 1(800)752-7014 | Maine Northeast Health Care Quality Foundation, 1(800)772-0151 in-state calls only |
| Idaho PRO West, 1(800)445-6941 TTY/TDD: 1(800)251-8890 | Kansas The Kansas Foundation For Medical Care, Inc., 1(800)432-0407 | Maryland Delmarva Foundation for Medical Care, 1(800)492-5811 |
| Illinois Illinois Foundation for Quality Health Care, 1(800)647-8089 | Kentucky Health Care Excel, Inc., 1(800)288-1499 | Massachusetts Massachusetts Peer Review Organization, 1(800)252-5533 in-state calls only |
| Indiana Health Care Excel, Inc., 1(800)288-1499 | Louisiana Louisiana Health Care Review, Inc., 1(800)433-4958 in-state calls only | Michigan Michigan Peer Review Organization, Inc., 1(800)365-5899 |

Section 7

Information for Your Local Area

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Minnesota

Stratis Health,
1(800)444-3423

Nebraska

Sunderbruch Corporation,
1(800)247-3004

New Mexico

New Mexico Medical
Review Association,
1(800)279-6824

Mississippi

Mississippi Foundation For
Medical Care, Inc.,
1(800)844-0600

Nevada

HealthInsight,
1(800)748-6773

New York

Island Peer Review
Organization - IPRO,
1(800)331-7767

Missouri

Missouri Patient Care
Review Foundation,
1(800)347-1016

New Hampshire

Northeast Health Care
Quality Foundation,
1(800)772-0151 in-state
calls only

North Carolina

Medical Review Of North
Carolina, Inc.,
1(800)722-0468

Montana

Mountain Pacific Quality
Health Foundation,
1(800)497-8232

New Jersey

The Peer Review
Organization of New Jersey,
Inc.,
1(800)624-4557 in-state
calls only

North Dakota

North Dakota Health Care
Review, Inc.,
1(800)472-2902 in-state
calls only

Section 7

Information for Your Local Area

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Northern Mariana Islands
Mountain Pacific Quality
Health Foundation,
1(800)524-6550

Pennsylvania
Keystone Peer Review
Organization - KePRO,
1(800)322-1914

South Dakota
South Dakota Foundation
for Medical Care, Inc.,
1(800)658-2285

Ohio
Ohio KePRO, Inc.,
1(800)589-7337

Puerto Rico
Quality Improvement
Professional Research
Organization,
1(800)981-5062 in-state
calls only

Tennessee
Mid South Foundation For
Medical Care, Inc.,
1(800)489-4633

Oklahoma
Oklahoma Foundation For
Medical Quality, Inc.,
1(800)522-3414 in-state
calls only

Rhode Island
Rhode Island Quality
Partners, Inc.,
1(800)662-5028

Texas
Texas Medical Foundation,
1(800)725-8315

Oregon
OMPRO,
1(800)344-4354

South Carolina
Carolina Medical Review,
1(800)922-3089 in-state
calls only

Utah
HealthInsight,
1(800)274-2290

Section 7

Information for Your Local Area

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Vermont

Northeast Health Care
Quality Foundation,
1(800)772-0151 in-state
calls only

Washington

PRO West,
1(800)445-6941
TTY/TDD: 1(800)251-8890

Wisconsin

MetaStar,
1(800)362-2320

Virgin Islands

Virgin Island Medical
Institute, Inc.,
1(340)712-2400
Note: 340-712-2444 Hotline

Washington D.C.

Delmarva Foundation for
Medical Care,
1(800)645-0011

Wyoming

Mountain Pacific Quality
Health Foundation,
1(800)497-8232

Virginia

Virginia Health Quality
Center,
1(800)545-3814 in-state
calls only
TTY/TDD: 1(800)828-1140

West Virginia

West Virginia Medical
Institute, Inc.,
1(800)642-8686x2266

Section 7

Information for Your Local Area

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

| | |
|--|--|
| Alabama 1(800)433-3966 in-state calls only | Illinois 1(312)814-2427 |
| Alaska 1(800)467-8725 in-state calls only | Indiana 1(800)622-4461 in-state calls only |
| American Samoa Number Not Available | Iowa 1(800)351-4664 |
| Arizona 1(800)325-2548 in-state calls only | Kansas 1(800)432-2484 in-state calls only |
| Arkansas 1(800)224-6330 | Kentucky 1(800)595-6053 |
| California 1(800)927-4357 in-state calls only | Louisiana 1(800)259-5301 in-state calls only |
| Colorado 1(800)930-3745 in-state calls only | Maine 1(800)300-5000 in-state calls only |
| Connecticut 1(800)203-3447 in-state calls only | Maryland 1(800)492-6116 |
| Delaware 1(800)282-8611 in-state calls only | Massachusetts 1(617)521-7794 |
| Florida 1(800)342-2762 in-state calls only | Michigan 1(877)999-6442 |
| Georgia 1(800)656-2298 in-state calls only | Minnesota 1(800)657-3602 in-state calls only |
| Guam Number Not Available | Mississippi 1(800)562-2957 in-state calls only |
| Hawaii 1(808)586-2790 Hawaii only | Missouri 1(800)726-7390 |
| Idaho 1(800)721-3272 in-state calls only | Montana 1(800)332-6148 in-state calls only |

Section 7

Information for Your Local Area

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

Nebraska

1(800)234-7119

Nevada

1(800)992-0900 in-state calls only

New Hampshire

1(800)852-3416

New Jersey

1(609)292-5360

New Mexico

1(800)947-4722 in-state calls only

New York 1(800)342-3736 Also has toll free Spanish Line 1-800-218-8222 In-State Only

North Carolina

1(800)443-9354 in-state calls only

North Dakota

1(800)247-0560

Northern Mariana Islands

Number Not Available

Ohio

1(800)686-1578

Oklahoma

1(800)522-0071 in-state calls only

Oregon

1(800)722-4134 in-state calls only

Pennsylvania

1(877)881-6388 in-state calls only

Puerto Rico

1(787)722-8686

Rhode Island

1(401)222-2223

South Carolina

1(800)768-3467 in-state calls only

South Dakota

1(605)773-3563

Tennessee

1(800)525-2816

Texas

1(800)252-3439

Utah

1(866)350-6242 in-state calls only

Vermont

1(800)631-7788 in-state calls only

Virgin Islands

1(340)774-7166

Virginia

1(800)552-7945 in-state calls only

Washington

1(800)397-4422

Washington D.C.

1(202)727-8000

West Virginia

1(800)642-9004 in-state calls only

Wisconsin

1(800)236-8517 in-state calls only

Wyoming

1(800)438-5768 in-state calls only



PHONE NUMBERS

Section 7

Information for Your Local Area

State Medical Assistance Office: Call about programs to help pay medical bills for people with low incomes.

Alabama

1(800)362-1504 in-state calls only

Alaska

1(800)211-7470 in-state calls only

American Samoa

1(808)587-3521

Arizona

1(800)523-0231

Arkansas

1(800)482-8988

California

1(916)636-1980

Colorado

1(800)221-3943

Connecticut

1(800)842-1508 in-state calls only

Delaware

1(800)372-2022 in-state calls only

Florida

1(888)419-3456

Georgia

1(800)766-4456

Guam

Number Not Available

Hawaii

1(808)587-3521

Idaho

1(877)200-5441

Illinois

1(800)252-8635 in-state calls only

Indiana

1(317)232-4966

Iowa

1(800)972-2017

Kansas

1(800)766-9012

Kentucky

1(800)635-2570

Louisiana

1(888)342-6207 in-state calls only

Maine

1(800)452-1926 in-state calls only

Maryland

1(800)492-5231

Massachusetts

1(800)841-2900

Michigan 1(800)642-3195 1-888-367-6557
(for recipients out of Michigan)

Minnesota

1(800)657-3659

Mississippi

1(800)421-2408 in-state calls only

Missouri

1(800)392-2161

Montana

1(800)362-8312

Section 7

Information for Your Local Area

State Medical Assistance Office: Call about programs to help pay medical bills for people with low incomes.

Nebraska

1(800)430-3244

Nevada

1(800)992-0900X4776 in-state calls only

New Hampshire

1(800)852-3345 in-state calls only

New Jersey

1(800)356-1561 in-state calls only

New Mexico

1(888)997-2583

New York

1(800)541-2831

North Carolina

1(800)662-7030 in-state calls only

North Dakota

1(800)755-2604

Northern Mariana Islands

1(808)587-3521

Ohio

1(800)324-8680

Oklahoma

1(800)522-0310 in-state calls only

Oregon

1(800)273-0557

Pennsylvania

1(800)692-7462

Puerto Rico

1(787)250-7429

Rhode Island

1(401)462-5300

South Carolina

1(803)898-2500

South Dakota

1(605)773-4678

Tennessee

1(800)669-1851

Texas

1(800)252-8263

Utah

1(800)662-9651

Vermont

1(800)250-8427

Virgin Islands

1(787)250-7429

Virginia

1(804)786-7933

Washington

1(800)562-3022

Washington D.C.

1(202)724-5506

West Virginia

1(304)558-1700

Wisconsin

1(800)362-3002

Wyoming

1(800)251-1269

PHONE NUMBERS

Section 7

Information for Your Local Area

Centers for Medicare & Medicaid Services (CMS) Regional Offices: Call for information about reporting a complaint directly to CMS.

1 (617) 565-1232

Connecticut, Maine, Massachusetts,
New Hampshire, Rhode Island, Vermont

1 (214) 767-6401

Arkansas, Louisiana, New Mexico,
Oklahoma, Texas

1 (212) 264-3657

New Jersey, New York, Puerto Rico,
Virgin Islands

1 (816) 426-2866

Iowa, Kansas, Missouri, Nebraska

1 (215) 861-4226

Delaware, Maryland, Pennsylvania,
Virginia, Washington, D.C., West Virginia

1 (303) 844-4024

Colorado, Montana, North Dakota,
South Dakota, Utah, Wyoming

1 (404) 562-7500

Alabama, Florida, Georgia, Kentucky,
Mississippi, North Carolina, South
Carolina, Tennessee

1 (415) 744-3602

American Samoa, Arizona, California,
Guam, Hawaii, Nevada, Northern Mariana
Islands

1 (312) 353-7180

Illinois, Indiana, Michigan, Minnesota,
Ohio, Wisconsin

1 (206) 615-2354

Alaska, Idaho, Oregon, Washington

Office for Civil Rights: Call for information about submitting a complaint about discrimination.

- You can call toll-free 1-800-368-1019, TTY/TDD: 1-800-537-7697 (for the hearing and speech impaired).
- Look at www.medicare.gov on the Web to get the local number or TTY/TDD number for your state. Click on "Helpful Contacts."



Section 8

Words To Know

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay or doesn't pay enough for a service you got or would like to get. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go to the hospital after 60 days, a new benefit period begins. You must pay an inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospitals - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Health Maintenance Organization (HMO), Medicare - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.

Inpatient Care - Health care that you get when you are admitted to a hospital.

Section 8

Words To Know

Lifetime Reserve Days - Sixty days that Medicare will pay for when you are in a hospital for more than 90 days in a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance amount (\$396 in 2001).

Limiting Charge - The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are used for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the local community; and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice Plan - A health plan, such as an HMO or Private Fee-for-Service plan offered by a private company and approved by Medicare. An alternative to the Original Medicare Plan.

Medicare-Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge."

Medicare Managed Care Plan - These are health care choices in some areas of the country. In most plans, except in emergencies or certain cases when care is urgently needed, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Private Fee-for-Service Plan - A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Section 8

Words To Know

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive Services - Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

Primary Care Doctor - A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Referral - An OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Section 8

Words To Know

Skilled Nursing Facility Care* - A level of care that must be given or supervised by licensed nurses. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Telemedicine - The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology 2000.



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You are protected from discrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or religion under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your state (see page 92).

NOTES

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
(Formerly the Health Care Financing Administration)
7500 Security Boulevard
Baltimore, Maryland 21244-1850**

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National Medicare Handbook; with a listing of important phone numbers for your area.

**To get this handbook on
Audiotape (English and
Spanish), in Braille, Large
Print (English and
Spanish), or Spanish, call
1-800-633-4227,
TTY/TDD: 1-877-486-2048
for the hearing and
speech impaired.**

**Look at www.medicare.gov on the Web, or
call 1-800-MEDICARE (1-800-633-4227) to
get help with your Medicare questions.**

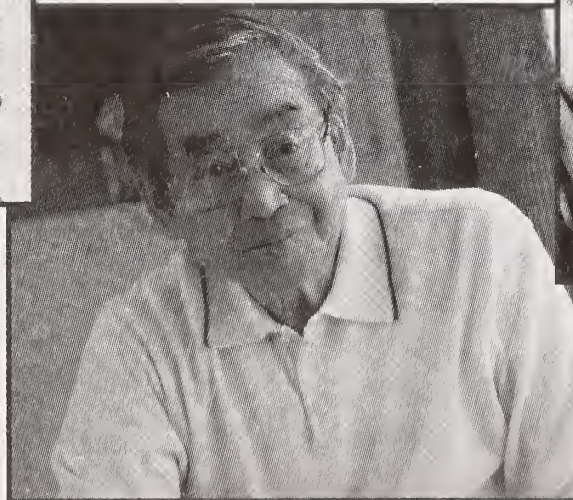
**¿Necesita usted una copia en español?
También está disponible en audiocasete y
letra grande. Llame gratis al
1-800-MEDICARE (1-800-633-4227).**

Choosing A Medigap Policy

To Supplement The Original Medicare Plan

NEW!

**6 Easy Steps To Buying A
Medigap Policy**



HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

Welcome to the 2001 Guide To Health Insurance For People With Medicare

“Choosing A Medigap Policy”

This Guide has 6 easy steps to buying a Medigap policy and other important tips to help you buy the Medigap policy that's right for you (see pages 20-32).

Don't feel like you have to read everything in this Guide all at once.

Section 1, which starts on page 9, has the basics you need to know about Medigap policies. Look over the list of topics in “What's In This Guide” on pages 2 and 3, and pick the one that you want to read. Then, work your way through the rest of Section 1 a page at a time.

Section 2, which starts on page 33, gives more details about Medigap policies for those who want them.

How This Guide Can Help You

Medicare is a federal health insurance program for people 65 years of age or older, and certain people with disabilities or End-Stage Renal Disease (permanent kidney failure). **It pays for much of your health care, but not all of it. There are some costs that you will have to pay yourself.** These costs are called your out-of-pocket costs.

There are other kinds of health insurance, like Medigap policies, that may help pay the costs that Medicare doesn't. This Guide is about "Medigap Policies," which are also called "Medicare Supplement Insurance." A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in the Original Medicare Plan coverage.

This Guide helps you understand:

- What Medigap policies are,
- How Medigap policies can help you, and
- What to do before you buy a Medigap policy.

Whether you need a Medigap policy is a decision only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a Medicare managed care plan, or a Private Fee-for-Service plan. You may also want to think about your long-term care needs (see page 37).

- ▶ Read over "A Quick Look At Medicare" on pages 4-8. This will help you understand what Medicare does and does not cover.
- ▶ Section 1, which starts on page 9, gives you the basics you need to know about Medigap policies.
- ▶ Section 2, which starts on page 33, has more details for those who want them.
- ▶ If you want information about other kinds of health insurance other than Medigap policies, see pages 34-39.

Words in red are defined on pages 77-79.

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Important: At the time of printing, the phone numbers listed were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD:1-877-486-2048 for the hearing and speech impaired) or look on the Internet at www.medicare.gov and select "Helpful Contacts."

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The 2001 Guide To Health Insurance For People With Medicare "Choosing A Medigap Policy" is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

A Quick Look At Medicare

Medicare has two parts:

1. Part A (Hospital Insurance)
2. Part B (Medical Insurance)

1. Part A (Hospital Insurance) helps pay for:

- Inpatient hospital care,
- Some skilled nursing facility care,
- Hospice care, and
- Some home health care.

For more information on what Medicare Part A covers, see the Part A coverage chart on page 68.

How To Get Medicare Part A

Most people get Medicare Part A automatically when they turn age 65. They do not have to pay a monthly payment called a premium for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show “Hospital Part A” on the lower left corner of the card. You can also call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Words in red are defined on pages 77-79.

A Quick Look At Medicare

2. Part B (Medical Insurance) helps pay for:

- Doctors' services,
- Outpatient hospital care, and
- Some other medical services that Part A doesn't cover (like some home health care).

Part B helps pay for these covered services and supplies when they are medically necessary.

You pay the Medicare Part B premium of \$50.00 per month in 2001. Rates can change every year. For some people, this amount may be higher if they did not choose Part B when they first became eligible at age 65. The cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases (see pages 6-7, "Special Enrollment Period For Part B"). You will have to pay this extra amount for the rest of your life.

For more information on what Medicare Part B covers, see the Part B coverage charts on pages 69-71.

How To Get Medicare Part B

You are automatically eligible for Part B if:

- You are eligible for premium-free Part A.
- You are a United States citizen or permanent resident age 65 or older.

Just before you turn 65 years old, you have to decide whether or not to take Part B. You should keep in mind that the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see pages 6-7 "Special Enrollment Period For Part B"). You will have to pay this extra amount for the rest of your life. If you choose to take Part B, Medicare takes this monthly premium out of your Social Security, Railroad Retirement, or Civil Service Retirement payment. If you don't get any of these payments, you will get a bill for the Part B premium every 3 months.

A Quick Look At Medicare

How To Get Medicare Part B (continued)

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods:

1. The General Enrollment Period
2. The Special Enrollment Period

1. The General Enrollment Period For Part B

This period runs from January 1 through March 31 of each year. During this time, you can sign up for Part B at your local Social Security office. Your Part B coverage will start on July 1 of that year. Remember, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below). You will have to pay this extra amount for the rest of your life.

2. The Special Enrollment Period For Part B

You can sign up during this period if you didn't take Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union.

You can sign up for Part B during the Special Enrollment Period:

- Anytime you are still covered by an employer or union group health plan through your or your spouse's **current or active** employment, or
- Within 8 months of the date when the employer or union group health plan coverage ends or when the employment ends (whichever is first).

Note: If you are still working and plan to keep your employer's group health coverage, you should talk to an expert to help you decide what is the best time to enroll in Part B. When you sign

(continued on page 7)

A Quick Look At Medicare

2. The Special Enrollment Period For Part B (continued)

up for Part B, you automatically begin your Medigap open enrollment period. Once your Medigap open enrollment period begins, it cannot be changed or restarted. See page 18 to learn more about your Medigap open enrollment period.

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible but do not sign up for Part B during the Special Enrollment Period, the cost of Part B may go up.

Call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) for more information about signing up for Medicare Parts A and B.

A Quick Look At Medicare

Medicare Health Plan Choices

Depending on where you live, you may be able to get your health care in one of 3 ways:

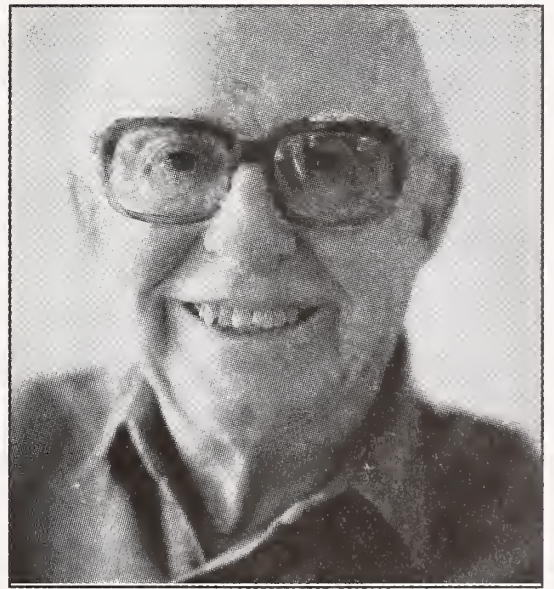
1. The Original Medicare Plan (also known as fee-for-service),
2. A Medicare managed care plan (like an HMO), or
3. A Private Fee-for-Service plan.

Note: Medigap policies only help pay health care costs if you are in the Original Medicare Plan.

For more information about your Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Ask for a FREE copy of the “**Medicare & You**” handbook. You can also read or print a copy of this handbook at www.medicare.gov on the Internet. Select “Publications.”

Words in red are defined on pages 77-79.

Section 1: The Basics



Section 1: The Basics

Learning About Medigap Policies

What Is A Medigap Policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

There are 10 standardized Medigap plans called “A” through “J.” **Each plan A through J has a different set of standardized benefits.** Plan A offers the least amount of benefits and Plan J offers the most benefits. **The chart on page 15 lists the benefits in the 10 standardized Medigap plans.**

If you live in **Massachusetts, Minnesota, or Wisconsin**, there are different types of Medigap plans that are sold in your state. For more information about the Medigap plans that are sold in your state, see pages 72-74.

When you buy a Medigap policy, you pay a premium to the insurance company. As long as you pay your premium, a policy bought after 1990 is automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium. You still must pay your monthly Medicare Part B premium.

However, in some states, insurance companies may refuse to renew Medigap policies that you bought before 1990. The law in these states did not say these policies had to be automatically renewed each year (guaranteed renewable) at the time these policies were sold.

Section 1: The Basics

What Is A Medigap Policy? (continued)

Medigap policies only help pay health care costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you are in a:

- Medicare managed care plan, or
- Private Fee-for-Service plan.

In fact, it is illegal for anyone to sell you a Medigap policy if they know you are in one of these plans.

If you have Medicaid, it is illegal for an insurance company to sell you a Medigap policy, except in certain situations (see page 39).

Can I keep seeing my same doctor if I buy a Medigap policy?

In most cases, yes. If you are in the Original Medicare Plan and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider who accepts Medicare. But if you have the type of Medigap policy called Medicare SELECT, you must use specific hospitals and, in some cases, doctors to get your full insurance benefits.

What is Medicare SELECT?

Medicare SELECT is a type of Medigap policy available in some states. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J. With a Medicare SELECT policy, generally you must use specific hospitals and, in some cases, doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally cost less.

If you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay what the Original Medicare Plan doesn't pay. The Original Medicare Plan will pay its share of approved charges no matter what hospital or doctor you choose.

Words in red are defined on pages 77-79.

Section 1: The Basics

Medigap Is Not...

- Coverage you get from your employer or union.
- A Medicare managed care plan (like an HMO).
- A Private Fee-for-Service plan.
- Medicare Part B.

Why Do I Need A Medigap Policy?

If you are in the Original Medicare Plan, a Medigap policy may help you:

- Lower your out-of-pocket costs.
- Get more health insurance coverage.

You may want to buy a Medigap policy because Medicare does not pay for all of your health care. There are “gaps” or costs that you must pay in the Original Medicare Plan. The chart on page 13 gives some examples of these gaps.

What you pay out-of-pocket in the Original Medicare Plan will depend on:

- Whether your doctor or supplier accepts “assignment” or takes Medicare’s approved amount as payment in full.
- How often you need health care.
- What type of health care you need.
- Whether you buy a Medigap policy.
- Which Medigap policy you buy.
- Whether you have other health insurance.

Words in red are defined on pages 77-79.

Section 1: The Basics

Gaps In The Original Medicare Plan

| Examples Of Gaps In Medicare Covered Services (What You Pay) | A Medigap Policy May Help Pay These Costs |
|---|--|
| Hospital Stays ▶ \$792 for days 1-60 ▶ \$198 per day for days 61-90 ▶ \$396 per day for days 91-150 | ✓ |
| Skilled Nursing Coinsurance ▶ Up to \$99 per day for days 21-100 | ✓ |
| Blood ▶ The first 3 pints | ✓ |
| Part B yearly deductible ▶ \$100 per year | ✓ |
| Part B covered services ▶ 20% of Medicare-approved amount (coinsurance) for most covered services ▶ 50% coinsurance for outpatient mental health treatment ▶ copayment for outpatient hospital services | ✓ |

Note: Some Medigap policies also cover other extra benefits that are not covered by Medicare like:

- Routine yearly check-ups.
- At-home recovery.
- Medicare Part B excess charge (the difference between your doctor's charge and Medicare's approved amount). The excess charge only applies if your doctor doesn't accept assignment.
- And more (see page 15).

You don't need a Medigap policy if you are in a Medicare health plan other than the Original Medicare Plan.

Section 1: The Basics

What Medigap Policies Cover

Each standardized Medigap policy must cover basic (core) benefits (see the chart on page 15). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance and outpatient copayment amounts. These policies may also cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to help pay more of those things that Medicare doesn't cover, like prescription drugs. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74.

What Medigap Policies Don't Cover

- Long-term care
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Unlimited prescription drugs

Who Can Buy A Medigap Policy?

To buy a Medigap policy, you generally must have Medicare Part A and Part B. If you are under age 65 and disabled or have ESRD (End-Stage Renal Disease), you may not be able to buy a Medigap policy until you turn 65.

See pages 44-45 if you want to know more about Medigap policies for people under age 65.

Words in red are defined on pages 77-79.

Remember, Medigap policies only work with the Original Medicare Plan.

Your Medigap Plan Choices - Medigap Plans A Through J

Medigap policies (including Medicare SELECT) can only be sold in 10 standardized plans. This chart gives you a quick and easy look at all the Medigap plans and their benefits. Read down to find out what benefits are in each plan. **For details about the Medigap plan extra benefits in the chart below, see pages 27-28. Note:** This chart does not apply if you live in Massachusetts, Minnesota, or Wisconsin (see pages 72-74).

Basic Benefits: (Included in All Plans)

- **Inpatient Hospital Care:** Covers the Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount) or copayment amount which may vary according to the service.
- **Blood:** Covers the first 3 pints of blood each year.

Section 1: The Basics

| A | B | C | D | E | F* | G | H | I | J* |
|-------------------|-------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------------------------------------|------------------------------------|---------------------------------------|
| Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit |
| | | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance |
| Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible |
| | Part B Deductible | Part B Deductible | | | Part B Deductible | | | | Part B Deductible |
| | | | | | Part B Excess (100%) | Part B Excess (80%) | | Part B Excess (100%) | Part B Excess (100%) |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | At-Home Recovery | | At-Home Recovery | At-Home Recovery | | At-Home Recovery | At-Home Recovery |
| | | | | | | | Basic Drug Benefit (\$1,250 Limit) | Basic Drug Benefit (\$1,250 Limit) | Extended Drug Benefit (\$3,000 Limit) |
| | | | | Preventive Care | | | | | Preventive Care |

* Plans F and J also have a high deductible option (see page 17).
Call your State Insurance Department for more information (see page 76).

Section 1: The Basics

How Much Do Medigap Policies Cost?

The cost for Medigap policies will be different depending on your age, where you live, and the insurance company from which you buy the policy. There can be big differences in the premiums that insurance companies charge for exactly the same coverage. When you compare premiums, be sure you are comparing the same Medigap policies.

Insurance companies have 3 different ways of pricing policies based on your age. In general, no-age-rated (also called community-rated) policies are the least expensive over your lifetime. For more details, see pages 40-41.

Other Factors That May Affect Your Cost:

- **Whether you are male or female.** Some companies offer discounts for females.
- **Whether you smoke or not.** Some companies offer discounts for non-smokers.
- **Whether you are married or not.** Some companies offer discounts for married couples.
- **Medical Underwriting.** This is a process that a company uses to review your health status and medical history, and decide whether to accept your application for insurance.

With medical underwriting, you usually must answer medical questions on an application. You need to fill out this application carefully. Some companies may want to review your medical record before they sell you a policy. The company may use this information to add a waiting period for pre-existing conditions if your state law allows. The company may also use this information to decide how much to charge you for a Medigap policy.

Insurance companies may “medically underwrite” any Medigap policy at times other than your open enrollment period or when you have the right to buy a Medigap policy (see page 18).

Section 1: The Basics

How Much Do Medigap Policies Cost? (continued)

Other Factors That May Affect Your Cost: (continued)

The company can not deny you coverage or charge you more for a policy if you are in your Medigap open enrollment period or when you have the right to buy a Medigap policy.

- **Buying A High Deductible Policy**

Insurance companies may offer a “high deductible option” on Medigap Plans F and J (see chart on page 15). If you choose this option, you must pay a \$1,580 deductible for the year 2001 before the plan pays anything. This amount can go up each year.

High deductible option policies often cost less, but if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

In addition to the \$1,580 deductible that you must pay for the high deductible option on Plans F and J, you must also pay deductibles for:

- Prescription drugs (\$250 per year for Plan J), and
 - Foreign travel emergency (\$250 per year for Plans F and J).
- **Buying A Medicare SELECT Policy**

Medicare SELECT is a type of Medigap policy available in some states. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J. With a Medicare SELECT policy, you must use specific hospitals and, in some cases, doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally cost less.

If you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what hospital or doctor you choose.

Words in red are defined on pages 77-79.

Section 1: The Basics

When Is The Best Time To Buy A Medigap Policy?

The best time to buy a Medigap policy is during your Medigap open enrollment period.

Your Medigap open enrollment period lasts for 6 months. It starts on the first day of the month in which you are both:

1. Age 65 or older, **and**
2. Enrolled in Medicare Part B.

Once the 6 month Medigap open enrollment period starts, it can't be changed.

During this period, an insurance company cannot:

- Deny you insurance coverage,
- Place conditions on a policy (like making you wait for coverage to start), or
- Change the price of a policy because of past or present health problems.

If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage (creditable coverage) you have. See page 42 for more information about pre-existing conditions.

If you want to know more about creditable coverage, see page 43. If you are disabled or have ESRD (End-Stage Renal Disease), see pages 44-45.

Section 1: The Basics

When Is The Best Time To Buy A Medigap Policy? (continued)

Medigap Open Enrollment Period Example:

Mr. Smith is 65 and has heart disease. He has just enrolled in Medicare Part B and his coverage starts on March 1, 2001. His Medigap open enrollment period is from March 1 through August 31. Mr. Smith has until August 31, 2001 to buy a Medigap policy without his heart disease affecting the cost or type of policy he can choose. After August 31, 2001, Mr. Smith will not have this guarantee.

How To Tell If You Are In Your Medigap Open Enrollment Period

Your red, white, and blue Medicare card shows the dates that your Part A and Part B coverage started. If you are age 65 or older, add 6 months to the date that your Part B coverage starts to figure out if you are in your Medigap open enrollment period. If that date is in the future, you are still in your Medigap open enrollment period. If that date is in the past, you have missed your Medigap open enrollment period.

Should I Enroll In Medicare Part B And Start My Medigap Open Enrollment Period If I Am Age 65 Or Over And Still Working?

You may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your or your spouse's **current or active** employment. Your Medigap open enrollment period won't start until after you sign up for Medicare Part B. Remember, once you're age 65 or older **and** enrolled in Medicare Part B, the Medigap open enrollment period starts and cannot be changed.

Section 1: The Basics

What If I Enrolled In Part B and Did Not Use My Medigap Open Enrollment Period To Buy A Medigap Policy?

If you apply for a Medigap policy after your open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept your application, and how much to charge you for the policy. If you are in good health, the insurance company is likely to accept your application, but there is no guarantee that you will get the policy.

Steps To Buying A Medigap Policy

Buying a Medigap policy is an important decision. Only you can decide if a Medigap policy is the right kind of health insurance coverage for you. If you decide to buy a Medigap policy, shop carefully. Look for a policy that you can afford and that gives you the coverage you need most. As you shop for a Medigap policy, keep in mind that insurance companies may charge different amounts for the same Medigap policy.

To buy a Medigap policy, follow steps 1-6 on pages 21-32.

Words in red are
defined on pages 77-79.

Section 1: The Basics

Steps To Buying A Medigap Policy (continued)



Step 1. Look At How Much You're Spending On Health Care Each Year.

Use the worksheet on page 23 to write down your yearly out-of-pocket costs for health care. If you don't know your yearly out-of-pocket costs, use the worksheet to check off the health care costs and services you paid out-of-pocket (see "How To Use The Worksheet" below and on page 22). This will help you decide which benefits you need. It will also help you when you begin to shop for the Medigap policy that's right for you.

Important: You should also think about your future health care needs. As you get older, your health care costs may increase.

How To Use The Worksheet

- Column 1 lists types of health care costs and services that you may have paid out-of-pocket last year. You can also add other health care costs or services that you used last year (or previous years) that you may want to think about when choosing a Medigap policy. Write those costs or services in the rows marked "Other."

If you use Column 2:

- Write down the cost for the services you used last year. If you don't know how much you paid out-of-pocket, ignore this column and use Column 3 (see page 22).
- Look at the amounts in Column 2. Rows with the largest amounts are most likely the benefits you may need in a Medigap policy right now. Remember, you should also think about your future health care needs (see pages 24-25). For example:

Let's say you did not have a hospital stay last year, so you did not have to pay a Medicare Part A hospital deductible. Next year, or sometime in the future, you may end up in a

(continued on page 22)

Section 1: The Basics

How To Use The Worksheet (continued)

hospital. If you did not buy a Medigap policy that covers the Part A hospital deductible, you will have to pay this cost (\$792 in 2001) for each benefit period.

If you use Column 3:

- Check off the costs and services you paid out-of-pocket last year (or previous years) using the list in Column 1. If some costs and services are not listed, write them in Column 1 in the rows marked "Other."
- Look at the costs and services you checked off. These are the benefits you may want to think about when choosing a Medigap policy.

Words in red are
defined on pages 77-79.

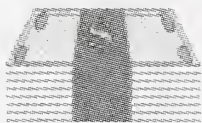
Section 1: The Basics

Yearly Health Care Cost Worksheet



| Column 1 | Column 2 | Column 3 |
|---|------------------------|---|
| Health Care Costs and Services | Amount Spent Last Year | Health Care Costs and Services Paid Out-of-Pocket (✓) |
| Medicare Part A Hospital Deductible | \$ | |
| Medicare Part B Yearly Deductible | \$ | |
| Prescription Drugs | \$ | |
| Skilled Nursing Coinsurance (Skilled care or rehabilitation services you received.) | \$ | |
| Foreign Travel Emergency (Any emergency care you received outside of the U.S.) | \$ | |
| At-Home Recovery (Help you received at home with daily activities like bathing and dressing if you are already getting Medicare covered home health visits.) | \$ | |
| Medicare Part B Excess Charge (The difference between your doctor's charge and Medicare's approved amount.) | \$ | |
| Preventive Care (Such as yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function test.) | \$ | |
| Other: | \$ | |
| Other: | \$ | |

Section 1: The Basics



Step 1. Look At How Much You're Spending On Health Care Each Year. (continued)

Now that you have completed the chart (see page 23), you should have a good idea of the types of benefits you want to look for in a Medigap policy. But don't stop here. **You should also think about benefits you may need in the future.**

Below is a list of health care benefits. Next to each benefit is a reason why you might need that benefit. Check off the benefits that you think you may need in the future. Add the benefits you checked off below to your list of benefits you may want in a Medigap policy.

Consider your medical history, your family medical history, and health risks when thinking about future health care costs.

- ☐ **Medicare Part A Hospital Deductible:** You may need this benefit if you have to stay in the hospital. The Part A deductible for 2001 is \$792. This amount can change every year. You have to pay this deductible for each benefit period.
- ☐ **Medicare Part B Yearly Deductible:** You may want to consider this benefit (which is \$100 in 2001) if you have Medicare Part B. Each year you must pay the Part B deductible before Medicare starts to pay its share. If you have this benefit, the Medigap plan would pay this amount each year.
- ☐ **Prescription Drugs:** You may think about this benefit if you have high prescription drug costs. Because it covers half your drug costs after the yearly deductible, to get the full benefit under Plans H and I, you should have at least \$2,750 in drug costs in a year (you pay \$1,250 plus \$250; plan pays \$1,250). To get the full benefit under Plan J, you should have at least \$6,250 in drug costs in a year (you pay \$3,000 plus \$250; plan pays \$3,000). See page 28 for more information on which Medigap plans cover prescription drugs.

Section 1: The Basics

Step 1. Look At How Much You're Spending On Health Care Each Year. (continued)

- ☐ **Skilled Nursing Coinsurance:** You may want to consider this benefit if you need to go to a Skilled Nursing Facility (SNF) after a hospital stay and stay in the SNF longer than 20 days.
- ☐ **Foreign Travel Emergency:** If you travel outside the United States, this benefit could save you money for emergency care.
- ☐ **At-Home Recovery:** This benefit covers additional care at home if you are already getting Medicare-covered home health services. It pays up to \$40 a visit and \$1,600 a year. This benefit may cost a lot and may not be worth the additional premiums you pay for it.
- ☐ **Medicare Part B Excess Charge:** Under federal law, doctors who don't accept "assignment" (take Medicare's approved amount as payment in full) may charge up to 15% more than the approved amount. You might want to think about this benefit if your doctors don't accept assignment. You may also want this benefit if you have to stay in the hospital and can't control whether the doctors you see accept assignment.
- ☐ **Preventive Care:** This benefit helps pay for routine yearly check-ups and tests that may be important to you to keep you healthy.

Section 1: The Basics



Step 2. Review The Medigap Plans And Decide Which Benefits You Want Or Need.

If you decide to buy a Medigap policy, make sure it covers the benefits you want or need. If you need help, call your State Health Insurance Assistance Program (see page 75). This program will give you free counseling to help you decide which Medigap policy is best for you.

Note: If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74 for the Medigap plans that are sold in your state.

Remember, all Medigap policies cover these Basic (Core) Benefits:

- The Part A coinsurance amount for days 61-90 (\$198 per day in 2001) and days 91-150 (\$396 per day in 2001) of a hospital stay.
- 100% of the cost for up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits.
- The first 3 pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.
- The coinsurance or copayment amount for Part B services after you meet the \$100 yearly deductible.

Most Medigap policies also cover extra benefits. The chart on pages 27-28 lists those extra benefits in the first column and the Medigap plans that cover those benefits in the second column.

1. Put a check next to the extra benefits you need or want (from worksheet in Step 1).
2. Turn to the chart on page 15 that lists all the Medigap plans and their benefits. On that chart, circle the benefits you checked off in the chart on pages 27-28.
3. Based on the benefits you circled, find the plan that has most, if not all, of the benefits you need. **The plan you choose may not match your needs exactly. You may have to give up or buy extra benefits to get a plan that is close to what you want.**

Section 1: The Basics

Medigap Policy Extra Benefits

Note: If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74 for the Medigap plans that are sold in your state.

| Medigap Policies pay for: | through plans: |
|--|-------------------------------|
| Medicare Part A Hospital Deductible <ul style="list-style-type: none">• \$792 in 2001. This amount can change every year. | B, C, D, E, F, G, H, I, and J |
| Skilled Nursing Coinsurance <ul style="list-style-type: none">• Up to \$99 a day for days 21-100 in a Skilled Nursing Facility. | C, D, E, F, G, H, I, and J |
| Medicare Part B Deductible <ul style="list-style-type: none">• \$100 per year. | C, F, and J |
| Foreign Travel Emergency (Emergency Care Outside the United States) <ul style="list-style-type: none">• 80% of the cost of emergency care during the first 60 days of each trip (after you pay the \$250 deductible).• Up to \$50,000 in your lifetime. | C, D, E, F, G, H, I, and J |
| At-Home Recovery <ul style="list-style-type: none">• The cost of at-home help with daily activities like bathing and dressing if you are already getting Medicare-covered home health visits.• Up to 8 weeks of at-home help after skilled care is no longer needed.• Will pay up to \$40 each visit and \$1,600 each year. | D, G, I, and J |

Section 1: The Basics

Medigap Policy Extra Benefits (continued)

| Medigap Policies pay for: | through plans: |
|---|----------------|
| Medicare Part B Excess Charge <ul style="list-style-type: none">• The difference between your doctor's actual charge and Medicare's approved amount.• Plans F, I, and J pay all of the excess charges.• Plan G pays 80% of the excess charges. | F, G, I, and J |
| Preventive Care (such as routine yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function test) <ul style="list-style-type: none">• Up to \$120 each year. | E and J |
| Prescription Drugs <ul style="list-style-type: none">• 50% of the drug costs that Medicare doesn't cover (after you pay a \$250 per year deductible).• Up to \$1,250 each year under Plans H and I.• Up to \$3,000 each year under Plan J. | H, I, and J |

Note: In most states, if you are not in good health, you may not be able to get policies with a prescription drug benefit unless you enroll during your Medigap open enrollment period.

Insurance companies may offer a high deductible option on Plans F and J. For more information on this option, see page 17.



Step 3. Find Out Which Insurance Companies Sell Medigap Policies In Your State.

To find out which insurance companies sell Medigap policies in your state:

- Call your State Health Insurance Assistance Program (see page 75). Ask if they have a Medigap comparison shopping guide for your state. These types of guides usually list the insurance companies that sell Medigap policies in your state and compare the costs of policies for each company.
- Call your State Insurance Department (see page 76).
- Look at www.medicare.gov on the Internet. Select “Medigap Compare” (see page 46).

This website has information on:

- ✓ Which Medigap policies are sold in your state.
- ✓ Tips on shopping for a Medigap policy.
- ✓ What the policies must cover.
- ✓ How insurance companies decide what to charge you for a Medigap policy premium.
- ✓ Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

You should plan to call more than one insurance company that sells Medigap policies in your state. Make sure the ones you choose to call are honest and reliable (see page 66).

Section 1: The Basics

Step 4. Call The Insurance Companies And Compare Costs.



Call different insurance companies and ask questions. Shopping around will help you find the best Medigap policy for you at a price you can afford.

It may not be good to **only** talk to a friend or relative about their Medigap policy when you are shopping for a policy. This is because the policy your friend has may not be the policy that best fits your needs or that you can afford. That's why it's important to call different insurance companies to shop around. Ask each insurance company:

- Is this insurance company licensed in this state? (The answer should be yes.)
- Which Medigap policies do you sell? (Make sure they sell the plan you want.)
- What is the cost of the Medigap policy I am interested in?
- How is this price decided?
 - ▶ What is the type of pricing used by the insurance company?
 - ▶ Does it make a difference if I am male or female?
 - ▶ Does it make a difference if I smoke or don't smoke?
 - ▶ Does it make a difference if I am married or single?
- Are there any additional benefits or discounts included in this policy?

If you are not in your Medigap open enrollment period, ask:

- Do you review my health records or application to decide how much to charge me for a Medigap policy?
- Will I have to wait for my pre-existing conditions to be covered if I already have a health problem?

Make sure you get the agents' and the companies' names, addresses, and telephone numbers.

Words in red are defined on pages 77-79.

Section 1: The Basics

Step 5. Choose The Best Medigap Policy For You.



After you call the insurance companies and compare their costs, choose the Medigap policy that is best for you.

But, before you make your final choice, make sure:

- ☒ You carefully review the Medigap policy benefits.
- ☒ You can afford the cost of the policy.
- ☒ The policy covers the benefits you need and want.
- ☒ You feel good about and trust your insurance company and/or the insurance agent.
- ☒ You have talked with someone you trust, like a family member or friend, about your choice.

Once you've checked the items above, you are now ready to move on to Step 6.

Section 1: The Basics

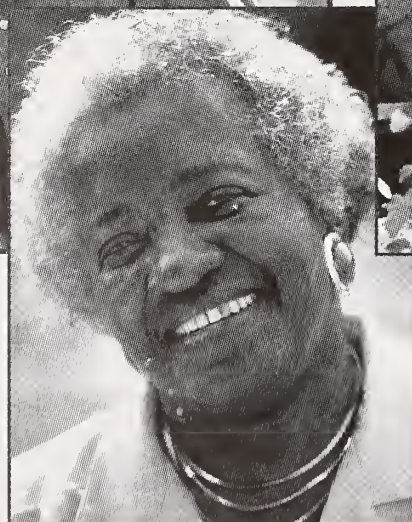
Step 6. Buy The Medigap Policy.



Once you have decided on the insurance company and the Medigap policy you want, you can buy your policy. When you buy your Medigap policy:

- ☒ Fill out your application carefully and completely. Answer all of the medical questions. If the insurance agent fills out the application, review it to make sure it's correct.
- ☒ Make sure the insurance company gives you a clearly worded summary of your Medigap policy. Read it carefully.
- ☒ Don't buy more than one Medigap policy. If you already have a Medigap policy, it is illegal for an insurance company to sell you a second policy unless you put in writing that you are going to cancel the first Medigap policy. Do not cancel your first Medigap policy until the second one is in place, and you decide to keep the second Medigap policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.
- ☒ Do not pay cash. Pay for your policy by check, money order, or bank draft.
- ☒ Ask for your Medigap policy to become effective whenever you want coverage to start, or when your previous policy's coverage ends. If for any reason the insurance company will not give you the start date you want, call your State Insurance Department (see page 76).
- ☒ Get a receipt with the insurance company's name, address, and telephone number for your records.
- ☒ Make sure you get your policy within 30 days. If you don't get your policy in 30 days, call your insurance company. If you don't get your policy in 60 days, call your State Insurance Department (see page 76).

Section 2: If You Want To Know More



Section 2: If You Want To Know More

Other Kinds Of Health Insurance

There are other kinds of health coverage, besides Medigap, that may pay for some of your health care costs not covered by Medicare. They include:

1. Employee or Retiree Coverage From an Employer or Union (see below)
2. COBRA Coverage (see pages 35-36)
3. The PACE Program (see page 36)
4. Federally Qualified Health Centers (see page 37)
5. Hospital Indemnity Insurance (see page 37)
6. Specified Disease Insurance (see page 37)
7. Long-Term Care Insurance (see page 37)
8. Medicaid (see pages 38-39)

1. Employee Or Retiree Coverage From An Employer Or Union

Call your benefits administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment. Since this kind of health coverage is not a Medigap policy, the rules that apply to Medigap policies do not apply.

Note: When you have retiree coverage from an employer or union, they have control over this coverage. They may change the benefits or premiums, and may also cancel the coverage if they choose.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your benefits administrator.

Note: If your coverage ends, you may have the right to buy a Medigap policy. Your employer or union should tell you within 60 days after the date your coverage ends. In some cases, the notice that your coverage has ended could be a letter telling you that your claim for payment has been denied, or that a claim your doctor sent in for payment was denied (see **Situation #2 on page 52**).

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

2. COBRA Coverage (Consolidated Omnibus Budget Reconciliation Act Of 1985)

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called "continuation coverage." You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents keep the group coverage for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Insurance Department to make sure (see page 76). In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefits administrator. If you don't get a notice, or if you get divorced, you should call your benefit administrator as soon as possible.

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare.

However, if you elect COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. If you only have Medicare Part A when your group health plan coverage ends (based on **current or active** employment), you can enroll in Medicare Part B during a special enrollment period without having to pay a Part B premium penalty. This means you have to sign up for Part B within 8 months of your group health coverage ending (see page 6). You will not get another Special Enrollment Period once COBRA coverage ends.

Section 2: If You Want To Know More

Remember, once you're age 65 or older and enrolled in Medicare Part B, the Medigap open enrollment period starts and cannot be changed (see page 18).

State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law. For more information about group health coverage under COBRA, call your State Insurance Department (see page 76).

3. The PACE Program (Programs Of All-Inclusive Care For The Elderly)

This program combines both inpatient and outpatient medical and long-term care services for eligible persons. To be eligible, you must:

- Be at least 55 years old,
- Live in the service area of a PACE program, and
- Be certified as eligible for nursing home care by the appropriate state agency.

The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

To find a PACE site near you, or for more information, call your state, county, or local medical assistance office - not a federal office. You can also look on the Internet at www.medicare.gov for PACE locations and telephone numbers. Select "Nursing Home Compare."

Section 2: If You Want To Know More

4. Federally Qualified Health Centers (FQHCs)

These are special health centers that can give you routine health care at a lower cost. FQHCs may include:

- A community health center,
- Tribal health clinic,
- Migrant health service, and
- Health center for the homeless.

To find the FQHC nearest you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired). Ask for the phone number of the Primary Care Association in your state. You can also look at www.medicare.gov on the Internet. Select "Helpful Contacts."

5. Hospital Indemnity Insurance

This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. **It does not fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any hospital stay you have.**

6. Specified Disease Insurance

This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. **It does not fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any specific disease you have.**

You may also get a FREE copy of "**Your Guide to Choosing A Nursing Home**" by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

7. Long-Term Care Insurance

This kind of insurance policy may cover medical care and non-medical care to help you with your daily needs, such as bathing, dressing, using the bathroom, and eating. Generally, **Medicare does not pay for long-term care.** For more information about long-term care insurance, get a copy of "**A Shopper's Guide to Long-Term Care Insurance**" from either your State Insurance Department (see page 76) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

Section 2: If You Want To Know More

8. Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most of your health care costs are covered if you qualify for both Medicare and Medicaid. People on Medicaid may also get coverage for nursing home care and outpatient prescription drugs which are not covered by Medicare.

States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income. To qualify for these programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than \$1,273 for an individual or \$1,714 for a couple. These income limits are slightly higher in Hawaii and Alaska. These income limits will change slightly in 2002.
- Have savings of \$4,000 or less for an individual or \$6,000 or less for a couple. Savings include money in a checking or savings account, stocks, or bonds.

If you think you qualify, call your state medical assistance office. To get this phone number, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also ask for information on "**Savings for Medicare Beneficiaries.**"

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

8. Medicaid (continued)

Can An Insurance Company Sell Me A Medigap Policy If I Already Have Medicaid?

If you have Medicaid, an insurance company can sell you a Medigap policy only in certain situations (see chart below).

| If... | Then you can buy... |
|---|--------------------------|
| Medicaid pays your Medigap premium | Any Medigap policy |
| Medicaid pays your Medicare premiums, deductibles, or coinsurance | Medigap plans H, I, or J |
| Medicaid only pays all or part of your Medicare Part B premium | Any Medigap policy |

In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you have Medicaid.

Section 2: If You Want To Know More

The Cost Of Medigap Policies: Ways Of Pricing Policies

Insurance companies have 3 different ways of pricing Medigap policies based on your age:

1. No-age-rated (also called community-rated)
2. Issue-age-rated
3. Attained-age-rated

1. No-age-rated (also called community-rated) policies

These policies charge everyone the same rate no matter how old they are.

Example*: Mrs. Smith pays the same monthly premium at each age plus any premium increases the company may charge because of inflation.

| | |
|---------------------------|-------|
| Monthly Premium at Age 65 | \$155 |
| Monthly Premium at Age 75 | \$155 |
| Monthly Premium at Age 85 | \$155 |

2. Issue-age-rated policies

The monthly premium for these policies is based on your age when you first buy the policy. The cost does not automatically go up as you get older. Your premium will be the same as any one buying a policy for the first time at your age.

Example*: Mrs. Smith pays the same monthly premium depending on how old she is when she buys the policy plus any additional premium increases the company may charge because of inflation.

Buy Policy at Age 65

| | |
|---------------------------|-------|
| Monthly Premium at Age 65 | \$130 |
| Monthly Premium at Age 75 | \$130 |
| Monthly Premium at Age 85 | \$130 |

Buy Policy at Age 75

| | |
|---------------------------|-------|
| Monthly Premium at Age 65 | -- |
| Monthly Premium at Age 75 | \$165 |
| Monthly Premium at Age 85 | \$165 |

* Remember, **all** monthly premiums may change and go up each year because of inflation and rising health care costs.

(continued on page 41)

Section 2: If You Want To Know More

The Cost Of Medigap Policies: Ways Of Pricing Policies (continued)

Buy Policy at Age 85

| | |
|---------------------------|-------|
| Monthly Premium at Age 65 | -- |
| Monthly Premium at Age 75 | -- |
| Monthly Premium at Age 85 | \$195 |

* Remember, **all** monthly premiums may change and go up each year because of inflation and rising health care costs.

3. Attained-age-rated policies

The monthly premiums for these policies are based on your age each year. These policies generally cost less at age 65, but their costs go up automatically as you get older.

Example*: Mrs. Smith pays higher monthly premiums as she gets older plus any additional premium increases the company may charge because of inflation.

| | |
|---------------------------|-------|
| Monthly Premium at Age 65 | \$115 |
| Monthly Premium at Age 75 | \$160 |
| Monthly Premium at Age 85 | \$190 |

Caution: In general, attained-age-rated policies cost less when you are 65 than issue-age-rated or no-age-rated policies. However, beginning somewhere between the ages of 70 and 75, attained-age-rated policies usually cost more than issue-age-rated or no-age-rated policies.

Section 2: If You Want To Know More

Medigap Coverage Of Pre-existing Conditions

What Is A Pre-existing Condition?

A pre-existing condition is a health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

Will My Pre-existing Condition Be Covered If I Buy A Medigap Policy?

If you buy a Medigap policy during your Medigap open enrollment period, the insurance company can refuse to cover care for pre-existing conditions for up to 6 months. This only applies to conditions that were diagnosed or treated during the 6 months immediately before the start of your Medigap policy. This 6-month period is called the pre-existing condition waiting period. However, they cannot refuse to cover pre-existing conditions if you have at least 6 months of creditable coverage. Any new health problem would be covered immediately, regardless of whether you had creditable coverage.

Words in red are
defined on pages 77-79.

Section 2: If You Want To Know More

Creditable Coverage

What Is Creditable Coverage?

Creditable coverage is any previous health coverage that can be used to shorten the pre-existing condition waiting period, such as coverage under:

- A group health plan (like an employer plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool
- TRICARE (the health care program for military dependents and retirees)
- The Federal Employees Health Benefit Plan
- A public health plan
- A health plan under the Peace Corps Act

Note: Whether you can use creditable coverage depends on whether you had any “breaks in coverage.” If there was any time that you had no health coverage of any kind, and during that time you were without coverage for more than 63 days in a row, you can only count creditable coverage that you had after that break in coverage.

Creditable Coverage Example:

Mr. Smith is 65 and has heart disease. His Medicare Part A and B started November 1, 2000. Before this date, he had no health insurance coverage. On March 1, 2001, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for 6 months (the pre-existing condition waiting period). However, Mr. Smith can use his 4 months of Medicare coverage to shorten this 6 month period. Now his waiting period will only be 2 months instead of 6 months. During these 2 months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease.

Section 2: If You Want To Know More

Medigap Policies For People Under Age 65 With A Disability Or End-Stage Renal Disease (ESRD)

You may have Medicare Part B benefits before age 65 due to a disability or ESRD (permanent kidney failure treated with dialysis or a kidney transplant). If you are under age 65 and disabled or have ESRD, you may not be able to buy the Medigap policy you want until you turn 65 because not all states require insurance companies to sell Medigap policies to people under age 65. You will have the right to choose and buy any Medigap policy when you turn age 65. It does not matter that you had Medicare Part B before you turned age 65.

For 6 months after you turn age 65 **and** are enrolled in Medicare Part B:

- You can buy any Medigap policy (including those policies that help pay the cost of prescription drugs), and
- Insurance companies cannot refuse to sell you a Medigap policy due to a disability or other health problem.

When you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage you have. If you had Medicare for more than 6 months, you will not have a pre-existing condition waiting period because Medicare counts as creditable coverage.

Several states require Medigap insurance companies to offer a limited Medigap open enrollment period for people with Medicare Part B who are under age 65. At the time of this printing, the following states require insurance companies to offer at least one

Section 2: If You Want To Know More

Medigap Policies For People Under Age 65 With A Disability Or End-Stage Renal Disease (ESRD) (continued)

kind of Medigap policy during a special open enrollment period to people with Medicare under age 65:

- California
- Connecticut
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- Texas
- Wisconsin

Also, some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Remember, if you live in a state that has a Medigap open enrollment period for people under age 65, you will still get another Medigap open enrollment period when you turn age 65.

Also, if you join a Medicare health plan and your coverage ends, you may have the right to buy a Medigap policy (see Situations #1 and #2 on pages 50-53).

If you have questions, you should call your State Health Insurance Assistance Program (see page 75).



Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Medigap Compare On The Internet

What Is Medigap Compare?

Medigap Compare is part of www.medicare.gov, a government website that has information on Medigap policies. It helps you find insurance companies in your state that sell Medigap policies, gives you information on how to contact the insurance companies, and, in some cases, gives you information to compare Medigap policies. This website has information on:

- Which Medigap policies are sold in your state.
- Tips on shopping for a Medigap policy.
- What the policies must cover.
- How insurance companies decide what to charge you for a Medigap policy premium.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

How To Use Medigap Compare

First, look on the Internet at www.medicare.gov and select "Medigap Compare." To compare Medigap policies in your state, follow these 4 steps:

1. Enter the zip code or state/territory where you live.
2. Select the insurance companies in your area that you want to compare.
3. See which insurance companies sell the plans you are interested in and how they price their plans based on what rating method they use (see pages 40-41).
4. Call the insurance company to get more information.

Section 2: If You Want To Know More

Your Rights To Buy A Medigap Policy In Certain Situations

If you lose certain types of health care coverage, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called “Medigap Protections.” They are also called “guaranteed issue” rights because the law says that insurance companies must issue you a policy.

Medigap protections are important because without them, if you do not buy a Medigap policy during your Medigap open enrollment period, an insurance company can refuse to sell you a policy, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back except in very limited circumstances.

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Summary of Medigap Protections

There are a few situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy.

For example:

1. Your Medicare managed care plan, Private Fee-for-Service plan, PACE provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see **Situation #1 on pages 50-52**), or
2. Your health coverage ends because of reasons other than a plan leaving the Medicare program (see **Situation #2 on pages 52-53**), or

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

3. You dropped your Medigap policy to join a Medicare managed care plan, Private Fee-for-Service plan, or PACE program and then leave the plan within one year after joining. Or you buy a Medicare SELECT policy for the first time and drop the policy within one year after buying (see **Situation #3 on page 54-55**).
4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract, or Private Fee-for-Service plan) or PACE program when you first became eligible for Medicare at age 65 and you leave the plan within one year of joining (see **Situation #4 on page 55-56**).
5. A change in your circumstances gives you the right to leave (disenroll from) your plan (see **Situation #5 on pages 56-57**).

The following pages have a summary of these situations and the protections that apply. In order to get these Medigap protections, you must meet certain conditions (see the summary for more details). All rights to buy Medigap policies under the following situations include Medicare SELECT policies since they are a type of Medigap policy.

The Medigap protections in this section are from federal law. Many states provide more Medigap protections than federal law. Call your State Health Insurance Assistance Program or State Insurance Department for more information (see pages 75-76).

If you live in **Massachusetts, Minnesota, or Wisconsin**, you have the right to buy a Medigap policy that is similar to the standardized policies you have a right to buy in other states. Call your State Insurance Department (see page 76).

Words in red are
defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Note: There may be times when more than one of these situations applies to you. When this happens, you can choose the protection that gives you the best choice of policies.

For example:

If both situations #1 and #4 apply to you, you may have the right to buy any Medigap policy.

- Situation #1 limits your choices to only Medigap plans A, B, C, or F that are sold in your state.
- Situation #4 offers you the best choice by allowing you to buy **any** Medigap policy that is sold in your state.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #1

Your Medicare managed care plan, Private Fee-for-Service plan, PACE provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

You have the right to buy Medigap plans A, B, C, or F that are sold in your state. You can apply for a Medigap policy as soon as you get the final notification letter from your plan. However, to protect your rights, you must apply no later than 63 calendar days after your health coverage ends.

You can choose to leave your plan any time after you get your final notification letter, or wait until your coverage ends. You can apply for your Medigap policy early, and ask for it to start when your plan coverage ends.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. Remember, there is no federal law that says insurance companies must sell Medigap plans to people under age 65.

Words in red are defined on pages 77-79.

Important: When your health coverage ends, your health plan will send you a final notification letter telling you that your

(continued on page 51)

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #1 (continued)

coverage is ending. Keep a copy of this letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

If you get a final notification letter telling you that your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or will no longer give care in your area, you may have 3 choices:

1. **Switch to another Medicare managed care plan or Private Fee-for-Service Plan in your area.** The final notification letter will tell you if there are other plans available in your area. In some cases, you may have to wait until the new plan you want to join is accepting new members. If you join a new Medicare health plan when your current plan coverage ends, you will not need (or be able to use) a Medigap policy.
2. **Leave your plan (disenroll) anytime between the date you get your final notification letter and when your health coverage ends.** Unless you join another Medicare health plan, you will automatically return to the Original Medicare Plan when you leave (disenroll from) your plan. You still have 63 calendar days from the day you leave your plan (disenroll) to apply for a Medigap policy.
3. **Stay in your plan until the date your coverage ends.** Unless you join another Medicare health plan, you will automatically return to the Original Medicare Plan when your coverage ends. You still have 63 calendar days after your health coverage ends to apply for a Medigap policy.

Another Option

If you joined a Medicare managed care plan or Private Fee-for-Service plan for the first time and you were in the plan less

(continued on page 52)

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

than one year before the plan left the Medicare program or stopped giving care in your area, you have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to return to your old Medigap policy if you dropped it to join the plan under Situation #3 (see page 54) or to buy any Medigap policy under Situation #4 (see page 55).

If you have ESRD:

A new law lets you join another Medicare managed care plan or Private Fee-for-Service plan if your plan left the Medicare program or stopped giving care in your area anytime after December 31, 1998.

Situation #2

Your health coverage ends because of reasons other than a plan leaving the Medicare program. This includes the following:

- Your Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, or PACE program ends your coverage because you move out of the plan's service area. You can apply for a Medigap policy after you get the termination notice, but must apply no later than 63 calendar days after the coverage ends.
- You are in an employer group health plan that pays some of the costs not paid for by Medicare, and the plan ends your coverage. If you are notified by your employer plan, you have 63 calendar days after you get the termination notice to apply for a Medigap policy.

Words in red are defined on pages 77-79.

Note: In some cases, the notice that your coverage has ended could be a letter telling you that your claim for payment has been denied, or that a claim your doctor sent in for payment was denied because your coverage has ended. If this happens, you have 63 calendar days after the date you get the notice to buy Medigap plans A, B, C, or F that are sold in your state.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #2 (continued)

- Your Medigap policy terminates because the insurance company goes bankrupt or is insolvent, and State law does not provide for you to get conversion coverage. You can apply for a new Medigap policy any time after you are notified in some way that the insurer is insolvent or that your coverage will be ending, or after your coverage actually ends, but you must apply no later than 63 calendar days after your coverage ends.

In these cases, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. **You must apply no later than 63 calendar days after your health coverage ends.**

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare.

Important: Keep a copy of any letters, notices, claims, or denials (make sure that your name is on it) and the postmarked envelopes to prove that you lost coverage from your health plan/policy. Keep a copy of any insurance company or provider claim denial letters. Make sure that your name is on the letter, and the postmarked envelope to prove that you lost coverage from your health plan/policy.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #3

You dropped your Medigap policy to join a Medicare managed care plan, Private Fee-for-Service plan, PACE program, or buy a Medicare SELECT policy, then leave the plan or policy, and:

- This is the first time that you have ever been enrolled in a Medicare managed care plan, Private Fee-for-Service plan, PACE program, or Medicare SELECT policy, and
- You leave the Medicare managed care plan, Private Fee-for-Service plan, PACE program, or Medicare SELECT policy within one year after joining.

You have the right to return to your former Medigap policy if the same insurance company still sells it.

If your former Medigap policy is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You have from 60 days before your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

Note: If you are still in your Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

Words in red are defined on pages 77-79.

Another Option

If you dropped a Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan for the first time and you were in the plan less than one year before the plan left the Medicare program or stopped giving care in your area, you

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #3 (continued)

have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to return to your old Medigap policy under this situation.

Caution: If you bought a Medigap policy before 1992, your policy is probably not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.

Situation #4

You joined a Medicare health plan when you first became eligible for Medicare at age 65, and you leave the health plan within one year after joining. This includes health plans like a Medicare managed care plan with a Medicare + Choice contract, a Private Fee-for-Service plan, or a PACE program.

You must be allowed to buy **any** Medigap policy sold in your state. You have from 60 days before your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

Note: If you are still in your Medigap open enrollment period when you leave your Medicare health plan, your right to buy any Medigap policy sold in your state lasts until the end of your open enrollment period. That may be longer than 63 calendar days after your coverage ends.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #4 (continued)

Another Option

If you joined a Medicare managed care plan or Private Fee-for-Service plan for the first time at age 65, and you were in it less than one year before the plan left the Medicare program or stopped giving care in your area, you have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to buy any Medigap policy under this situation.

Situation #5

A change in your circumstances gives you the right to leave (disenroll from) your plan. This includes the following:

- You move out of the service area of your Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, or PACE program.
- You leave the health plan because it failed to meet its contract obligations to you (for example, the marketing materials were misleading or quality standards were not met).

You have the right to buy Medigap plans A, B, C, or F that are sold in your state or the new state if you are moving. You have from 60 days before you leave your plan and your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Cannot charge you more for a policy because of past or present health problems.

Section 2: If You Want To Know More

Situation #5 (continued)

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Where To Get More Information About Medigap Protections

- Call your State Health Insurance Assistance Program (see page 75) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that's right for you.
- Call your State Insurance Department (see page 76) if you are denied Medigap coverage.

Section 2: If You Want To Know More

Losing Medigap Coverage

Can My Medigap Insurance Company Drop Me?

In most cases, no. If you bought your Medigap policy after 1990, the law says the policy is guaranteed renewable. This means that your insurance company must let you renew your Medigap policy unless you do not pay the premiums, you lie (for example, you don't tell the insurance company everything about your health), or you commit fraud under the policy. There is only one situation where you may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, and state law does not make some other coverage available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see Medigap Protections, Situation #2 on pages 52-53).

Insurance companies in some states may refuse to renew Medigap policies that you bought before 1990. The law, in some states, did not say these policies had to be guaranteed renewable at the time they were sold. If an insurance company refuses to renew one of these older Medigap policies, the company must cancel all policies of this type that they sell in your state. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see example below and Medigap Protections, Situation #2, on pages 52-53).

Example:

In 1987, Mr. Jones bought a Medigap policy from Company A. The Medigap policy Mr. Jones bought is not guaranteed renewable because he bought it before 1990, and it did not say it was guaranteed renewable. Company A will not renew Mr. Jones's policy because it is no longer being offered. The company is canceling all policies of this type in the state. Therefore, Mr. Jones has the right to buy Medigap policies A, B, C, or F that are sold in his state.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Switching Medigap Policies

Do I Have To Switch If I Have An Older Medigap Policy?

No. If you have an older Medigap policy, you can keep it. You don't have to switch it for one of the newer standardized Medigap plans. But, if you decide to switch your Medigap policy, you will not be able to go back to your older Medigap policy if you bought it before 1992 when standardized policies were first sold.

What Should I Do Before Switching My Medigap Policy?

Before switching policies, compare benefits and premiums. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and long-term care. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies.

Do I Have To Wait A Certain Length Of Time Before I Can Switch To A Different Medigap Policy?

No. But the length of time you had your policy will affect how your new policy covers you for pre-existing conditions.

If you've had a Medigap policy for at least 6 months and you decide to switch, your new Medigap policy generally must cover you for all pre-existing conditions. If you have had a Medigap policy for less than 6 months, the new policy must give you credit for the time the older policy covered you (see "What is creditable coverage?" on page 43).

If there is a benefit in the new Medigap policy that was not in your older policy, the company can make you wait up to 6 months before covering that benefit.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Medigap Coverage If You Move

What Happens To My Medigap Policy If I Move?

Because your Medigap policy is guaranteed renewable, you will still have coverage if you move. However, if you move to a new state, the company may charge you a different premium.

If you have a Medicare SELECT policy and you move out of the plan's service area, you have to change your insurance coverage. You have the right to buy Medigap plans A, B, C, or F that are sold in the new state where you move (see Situation #5 on pages 56-57).

Words in red are
defined on pages 77-79.

Section 2: If You Want To Know More

How Your Bills Get Paid

Does The Medigap Insurance Company Pay My Doctor or Provider Directly?

The insurance company must pay your doctor or provider directly when:

- Your doctor or provider has signed an agreement with Medicare to accept assignment of all Medicare claims for all people with Medicare,
- Your policy is a Medigap policy, and
- You tell your doctor's office to put on the Medicare claim form that you want Medigap insurance benefits paid to the doctor or supplier. Your doctor should put your Medigap policy number and the company name on the Medicare claim form. You will need to sign the claim form. Make sure this information is correct.

When these conditions are met, the Medicare carrier will process the claim and send it to the Medigap insurance company. The carrier will send you an Explanation of Medicare Benefits (EOMB) or a Medicare Summary Notice (MSN). Your Medigap insurance company will pay your doctor or provider directly and then send you a notice. If you don't get this notice, you may ask your Medigap insurance company for it.

In most cases, Medicare claims are sent directly to the insurance company, even if the doctor does not accept assignment on all claims.

If Your Doctor Is Not Paid Directly

If the Medigap insurance company does not pay your doctor directly when the above three conditions are met, you should report this to your State Insurance Department (see page 76). For more information on Medigap claim filing by the carrier, call your Medicare carrier. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get the telephone number of the Medicare carrier in your state.

Section 2: If You Want To Know More

Private Contracts

What Is A Private Contract?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. It only applies to the services given by the doctor who asked you to sign it.

If I Sign A Private Contract With My Doctor, Will Medicare And My Medigap Policy Pay?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services given by the doctor who asked you to sign it. This means that Medicare and Medigap will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. **Note:** You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor:

- Medicare will not pay for any of the services this doctor gives you.
- Your Medigap policy, if you have one, will not pay anything for services this doctor gives you.
- You will have to pay whatever this doctor or provider charges you. (The limiting charge will not apply.)
- Medicare managed care plans or Private Fee-for-Service plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- Many other insurance plans will not pay for these services either. (Call your insurance company before you get the service.)
- The doctor must tell you if he or she has been excluded from the Medicare program.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

You Can Pay On Your Own For Services That Medicare Doesn't Cover

You may choose to pay on your own for services the Original Medicare Plan doesn't cover. In this case, your doctor does not have to stop giving services through Medicare or ask you to sign a private contract. You are always free to get services that Medicare doesn't cover, but you must pay for the services yourself.

Medicare may refuse to pay for services that aren't medically necessary. If that happens, a Medigap policy will not pay any coinsurance or deductible amounts on the cost of these services.

Some of the 10 standardized Medigap policies have certain benefits that pay for limited types of services that Medicare never covers. For example:

- The foreign travel emergency benefit in plans C, D, E, F, G, H, I, and J,
- The prescription drug benefit in plans H, I, and J,
- The at-home recovery benefit in plans D, G, I, and J, and
- The preventive care benefit in plans E and J.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Watch Out for Illegal Insurance Practices

It is illegal for anyone to:

- Pressure you into buying a Medigap policy, or lie to you or mislead you to get you to switch from one company or policy to another.
- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have Medicaid, except in certain situations (see page 39).
- Sell you a Medigap policy if they know you are enrolled in a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan.
- Claim that a Medigap policy is part of the Medicare program or any other federal program.
- Sell you a Medigap policy that can't be sold in your state. Some Medigap insurance companies use direct mail advertising to sell policies. You should make sure that the Medigap plan you are interested in can be sold in your state.
- Misuse the names, letters, symbols, or emblems of the U. S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs like Medicare.

If you believe that a federal law has been broken, you may call 1-800-MEDICARE (1-800-633-4227, TTY/ TDD: 1-877-486-2048 for the hearing and speech impaired). In most cases, however, your State Insurance Department can help you with insurance-related problems (see page 76).

Section 2: If You Want To Know More

Discrimination

Every facility or agency that takes part in the Medicare program must follow the law. It's illegal to discriminate (treat a person differently from everyone else) based on:

- Race,
- Color,
- Sex,
- Disability,
- Age, or
- National origin.

If you believe that you have been discriminated against in any of these 6 categories, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 (TTY/ TDD: 1-800-537-7697 for the hearing and speech impaired).

Section 2: If You Want To Know More

Ways To Check If An Insurance Company Is Reliable

Buying a Medigap policy is an important decision. You want to make sure that you are buying from a reliable insurance company. To help you decide if an insurance company is reliable, you can:

- Call the **State Insurance Department** in your state (see page 76). Ask if they keep a record of complaints against insurance companies and whether these can be shared with you.
- Go to your local public library.

Your local public library can help you:

- ▶ Get information on an insurance company's financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poors.
- ▶ Look at information on the Internet.
- Talk to someone you trust, like your insurance agent or a friend who has a Medigap policy.
- Call the **State Health Insurance Assistance Program** in your state (see page 75). These programs provide free counseling about Medigap policies.

Section 2: If You Want To Know More

Medicare Part A and Part B Coverage Charts

| For: | See page(s): |
|------|--------------|
|------|--------------|

| | |
|-----------------------------|-------|
| Part A (Hospital Insurance) | 68 |
| Part B (Medical Insurance) | 69-71 |

If you have general questions about Medicare Part A, call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your Fiscal Intermediary.

If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). Call 1-800-MEDICARE (1-800-633-4227) to get these phone numbers.

You can also get these phone numbers at www.medicare.gov on the Internet. Select "Helpful Contacts."

Section 2: If You Want To Know More

Medicare Part A (Hospital Insurance) Helps Pay For:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, a private room unless medically necessary, or a television or telephone in your room. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.

Skilled Nursing Facility (SNF) Care:**

Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).

Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.

Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.

Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

What YOU Pay in 2001* in the Original Medicare Plan

For each benefit period YOU pay:

- A total of \$792 for a hospital stay of 1-60 days.
- \$198 per day for days 61-90 of a hospital stay.
- \$396 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 77.)
- All costs for each day beyond 150 days.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to \$99 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

YOU pay:

- Nothing for home health care services.
- 20% of the Medicare-approved amount for durable medical equipment.

YOU pay:

- A copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year.

YOU pay:

For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.

** You must meet certain conditions in order for Medicare to cover these services.

Section 2: If You Want To Know More

Medicare Part B (Medical Insurance) Helps Pay For:

Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions.

Also covers outpatient physical and occupational therapy including speech-language therapy.

Outpatient mental health care.

Clinical Laboratory Service: Blood tests, urinalysis, and more.

Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.

Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.

Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.

What YOU Pay in 2001* in the Original Medicare Plan

YOU pay:

- \$100 deductible (pay once per calendar year).
- 20% of Medicare-approved amount after the deductible, except in the outpatient setting.

- 20% for all outpatient physical, occupational, and speech-language therapy services.

- 50% for outpatient mental health care.

YOU pay:

- Nothing for Medicare-approved services.

YOU pay:

- Nothing for Medicare-approved services.
- 20% of Medicare-approved amount for durable medical equipment.

YOU pay:

- A coinsurance or copayment amount which may vary according to the service.

YOU pay:

For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.

** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept assignment, and you may have to pay the entire cost. Medicare will then send you its share of the costs. If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC).

Section 2: If You Want To Know More

Medicare Part B Covered Preventive Services

Who is covered...

What YOU pay in the Original Medicare Plan...

Bone Mass Measurements:

Varies with your health status.

Certain people with Medicare who are at risk for losing bone mass.

20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B deductible.

Colorectal Cancer Screening:

- Fecal Occult Blood Test - Once every 12 months.
- Flexible Sigmoidoscopy* - Once every 48 months.
- Colonoscopy* - Once every 24 months if you are at high risk for colon cancer. Starting July 1, 2001, once every 10 years but not within 48 months of a screening sigmoidoscopy, if you are not at high risk for colon cancer.
- Barium Enema - Doctor can decide to use instead of sigmoidoscopy or colonoscopy.

All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.

Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. *(For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.)

Diabetes Services:

- Coverage for glucose monitors, test strips, and lancets.
- Diabetes self-management training.

All people with Medicare who have diabetes (insulin users and non-users).

If requested by your doctor or other provider and you are at risk for complications from diabetes.

20% of the Medicare-approved amount after the yearly Part B deductible.

20% of the Medicare-approved amount after the yearly Part B deductible.

Mammogram Screening:

Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)

Starting April 1, 2001, Medicare covers new digital technologies for mammogram screenings.

All women with Medicare age 40 and older.

20% of the Medicare-approved amount with no Part B deductible.

(continued on page 71)

Section 2: If You Want To Know More

| Medicare Part B Covered Preventive Services | Who is covered... | What YOU pay in the Original Medicare Plan... |
|---|--|---|
| <p>Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.</p> <p>Starting July 1, 2001, pap smear and pelvic examinations are covered once every 24 months.</p> | <p>All women with Medicare.</p> | <p>Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.</p> |
| <p>Prostate Cancer Screening:</p> <ul style="list-style-type: none"> • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months. | <p>All men with Medicare age 50 and older.</p> | <p>Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.</p> |
| <p>Shots (vaccinations):</p> <ul style="list-style-type: none"> • Flu Shot - Once a year in the fall or winter. • Pneumonia Shot - One shot may be all you will ever need. Ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis. | <p>All people with Medicare.</p> | <p>Nothing for flu and pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.</p> |

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Massachusetts

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

| Medigap Benefits | Core | Supplement 1 | Supplement 2 |
|--|---------------------------|---------------------------|---------------------------|
| Basic Benefits | ✓ | ✓ | ✓ |
| Part A: Inpatient Hospital Deductible | | ✓ | ✓ |
| Part A: Skilled-Nursing Facility Coinsurance | | ✓ | ✓ |
| Part B: Deductible | | ✓ | ✓ |
| Foreign Travel Emergency | | ✓ | ✓ |
| Inpatient Days in Mental Health Hospitals | 60 days per calendar year | 120 days per benefit year | 120 days per benefit year |
| Prescription Drugs ((\$35 deductible each calendar quarter, then 100% coverage for generic drugs and 80% coverage for brand name drugs) | | | ✓ |
| State-Mandated Benefits (Annual Pap Smear tests and mammograms. Check your plan for other state-mandated benefits.) | ✓ | ✓ | ✓ |

For more information on these policies, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select "Medigap Compare."

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Minnesota

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A coinsurance.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

| Medigap Benefits | Basic | Extended Basic |
|--|-------|----------------|
| Basic Benefits | ✓ | ✓ |
| Part A: Inpatient Hospital Deductible | | ✓ |
| Part A: Skilled-Nursing Facility Coinsurance | ✓ | ✓ |
| Part B: Deductible | | ✓ |
| Foreign Travel Emergency | 80% | 80% |
| Outpatient Mental Health | 50% | 50% |
| Usual and Customary Fees | | 80% |
| Preventive Care | ✓ | ✓ |
| Prescription Drugs | | 80% |
| At-home Recovery | | ✓ |
| Physical Therapy | 20% | 20% |
| Coverage while in a Foreign Country | | 80% |

Optional Riders

- Part A: Inpatient Hospital Deductible
- Part A: Deductible
- Usual and Customary Fees
- Preventive Care
- Prescription Drugs
- At-home recovery

Insurance companies are allowed to offer six additional riders that can be added to a Basic plan. You may choose any one or all of the riders to design a Medigap plan that meets your needs.

For more information on these policies, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select "Medigap Compare."

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Wisconsin

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A coinsurance.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

| Medigap Benefits | Basic Plan |
|--|---|
| Basic Benefits | ✓ |
| Part A: Skilled-Nursing Facility Coinsurance | ✓ |
| Inpatient Mental Health Coverage | 175 days per lifetime in addition to Medicare |
| Home Health Care | 40 visits in addition to those paid by Medicare |
| Part B: Coinsurance | ✓ |
| Outpatient Mental Health | ✓ |
| Prescription Drugs | ✓ |

Wisconsin also has many other state mandated benefits under the Medigap Basic Plan. For more information, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select "Medigap Compare."

Optional Riders

- Medicare Part A Deductible Rider
- Additional Home Health Care Rider (365 visits including those paid by Medicare)
- Medicare Part B Deductible Rider
- Medicare Part B Excess Charges Rider
- Outpatient Prescription Drug Rider
- Foreign Travel Rider

Insurance companies are allowed to offer additional riders to a Medigap plan.

Where To Call For Help

State Health Insurance Assistance Program (SHIP): Call for help with buying a Medigap policy, or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, for help choosing a Medicare health plan, or Medicare bills.

| SHIP | Phone Number | SHIP | Phone Number |
|----------------|----------------|--------------------------|-----------------------------|
| Alabama | (800) 243-5463 | Nevada | (800) 307-4444 |
| Alaska | (907) 269-3680 | New Hampshire | (603) 225-9000 |
| American Samoa | (888) 875-9229 | New Jersey | (609) 588-3139 |
| Arizona | (800) 432-4040 | New Mexico | (505) 827-7640 |
| Arkansas | (800) 224-6330 | New York | (800) 333-4114 |
| California | (800) 434-0222 | North Carolina | (919) 733-0111 |
| Colorado | (888) 696-7213 | North Dakota | (800) 247-0560 |
| Connecticut* | (860) 424-5245 | Northern Mariana Islands | (888) 875-9229 |
| Delaware | (302) 739-6266 | Ohio | (800) 686-1578 |
| Florida | (800) 963-5337 | Oklahoma | (405) 521-6628 |
| Georgia | (800) 669-8387 | Oregon | (503) 947-7263 |
| Guam | (888) 875-9229 | Pennsylvania | (800) 783-7067 |
| Hawaii | (888) 875-9229 | Puerto Rico | (787) 721-8590 |
| Idaho | (208) 334-4350 | Rhode Island | (401) 222-2880 |
| Illinois | (217) 785-9021 | South Carolina | (803) 898-2850 |
| Indiana | (317) 233-3475 | South Dakota | (605) 773-3656 |
| Iowa | (800) 351-4664 | Tennessee | (800) 525-2816 |
| Kansas | (316) 337-7386 | Texas | (800) 252-9240 |
| Kentucky | (502) 564-2347 | Utah | (801) 538-3910 |
| Louisiana | (225) 342-5301 | Vermont | (802) 748-5182 |
| Maine | (207) 623-1797 | Virgin Islands | (340) 778-6311 ext. 2338 |
| Maryland | (410) 767-1100 | Virginia | (800) 552-3402 |
| Massachusetts | (617) 727-7750 | Washington | (800) 397-4422 |
| Michigan | (800) 803-7174 | Washington D.C. | (202) 739-0668 |
| Minnesota | (800) 333-2433 | West Virginia | (877) 987-4463 |
| Mississippi | (800) 948-3090 | Wisconsin | (800) 242-1060 |
| Missouri | (800) 390-3330 | Wyoming | (800) 856-4398 |
| Montana | (406) 444-7781 | | |
| Nebraska | (800) 234-7119 | | |

* Connecticut in-state calls only (800) 994-9422

Where To Call For Help

State Insurance Department: Call with questions about the Medigap policies sold in your area and any insurance-related problems.

| State Insurance Department | Phone Number | State Insurance Department | Phone Number |
|----------------------------|----------------|----------------------------|----------------|
| Alabama | (334) 269-3550 | Nevada | (775) 687-4270 |
| Alaska | (907) 269-7900 | New Hampshire | (800) 852-3416 |
| American Samoa | (808) 586-2790 | New Jersey | (609) 292-5360 |
| Arizona | (602) 912-8444 | New Mexico | (505) 827-4601 |
| Arkansas | (800) 224-6330 | New York | (212) 480-6400 |
| California | (213) 897-8921 | North Carolina | (919) 733-0111 |
| Colorado | (303) 894-7499 | North Dakota | (800) 247-0560 |
| Connecticut* | (860) 297-3800 | Northern Mariana Islands | (808) 586-2790 |
| Delaware | (302) 739-4251 | Ohio | (614) 644-2673 |
| Florida | (850) 922-3100 | Oklahoma | (405) 521-2828 |
| Georgia | (404) 656-2070 | Oregon | (503) 947-7984 |
| Guam | (808) 586-2790 | Pennsylvania | (717) 787-2317 |
| Hawaii | (808) 586-2790 | Puerto Rico | (787) 722-8686 |
| Idaho | (208) 334-4250 | Rhode Island | (401) 222-2223 |
| Illinois | (312) 814-2427 | South Carolina | (803) 737-6180 |
| Indiana | (317) 232-2395 | South Dakota | (605) 773-3563 |
| Iowa | (515) 281-5705 | Tennessee | (800) 525-2816 |
| Kansas | (785) 296-3071 | Texas | (800) 252-3439 |
| Kentucky | (800) 595-6053 | Utah | (801) 538-3077 |
| Louisiana | (225) 342-5301 | Vermont | (802) 828-2900 |
| Maine | (207) 624-8475 | Virgin Islands | (340) 774-7166 |
| Maryland | (800) 492-6116 | Virginia | (804) 371-9691 |
| Massachusetts | (617) 521-7794 | Washington | (800) 397-4422 |
| Michigan | (877) 999-6442 | Washington D.C. | (202) 727-8000 |
| Minnesota | (651) 296-4026 | West Virginia | (304) 558-3386 |
| Mississippi | (601) 359-3569 | Wisconsin | (608) 266-3585 |
| Missouri | (800) 726-7390 | Wyoming | (307) 777-7401 |
| Montana | (406) 444-2040 | | |
| Nebraska | (800) 234-7119 | | |

Words You Should Know

Assignment: In the Original Medicare Plan, a process in which a doctor or supplier agrees to accept the amount Medicare approves as full payment. You must pay any coinsurance amount.

Benefit Period: The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance: The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment: In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible: The amount you must pay for health care, before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

End-Stage Renal Disease: Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Excess Charges: The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Guaranteed Issue Rights: A right you have in certain situations when insurance companies are required by law to issue you a Medigap policy.

Guaranteed Renewable: A right you have that requires your insurance company to allow you to automatically renew or continue your Medigap policy, unless you do not pay your premiums.

Home Health Care: Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Hospice Care: Is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).

Lifetime Reserve Days: Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$396 in 2001).

Limiting Charge: The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Words You Should Know

Long-term Care: Custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses. Long-term care is not covered by Medicare.

Medical Underwriting: The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medically Necessary: Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare-approved Amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan: These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare SELECT: A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Open Enrollment Period (Medigap): A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your health history during this time.

Original Medicare Plan: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-existing Condition (Medigap): A health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

Premium: What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan: A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Words You Should Know

Programs of All-Inclusive Care For The Elderly (PACE): PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Skilled Nursing Facility: A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

Waiting Period: The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
7500 Security Boulevard
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and the National Association of Insurance Commissioners



To get the *2001 Guide To Health Insurance For People With Medicare: Choosing a Medigap Policy* on audio-tape (English and Spanish), in large print (English and Spanish), or in Braille, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

¿Necesita usted una copia de esta guía en Español? También está disponible en audiocassette y letra grande. Llame gratis al 1-800-MEDICARE (1-800-633-4227).

Where To Get Your Medicare Questions Answered



Call the Medicare Helpline

1-800-MEDICARE (English and Spanish)

1-800-633-4227

TTY/TDD: 1-877-486-2048

- General Medicare information.
- Medicare booklets. May also be available in audiotape (English and Spanish), Braille, Spanish, Chinese, and large print (English and Spanish).
- Answers to Medicare Part A and Part B coverage questions.
- Information about Medicare health plan choices in your area including cost, benefits, quality, and other information.
- Information about Medicare patients' rights and appeal rights.
- Information about nursing homes in your area.
- Information about Medicare events and activities in your area.
- The most up-to-date phone numbers (including TTY/TDD) for information on Medicare bills and services; and general information on: fraud and abuse, buying Medigap or long-term care insurance, appeals and complaints, and programs to help pay medical bills for people with a low income.

For more information, see your *Medicare & You* handbook. If you need a copy, call 1-800-MEDICARE (1-800-633-4227).

Hours to Call:

- 8:00 a.m. – 4:30 p.m., Monday through Friday in your time zone to speak to an English- or Spanish-speaking operator.
- 24 hours a day, 7 days a week to listen to pre-recorded answers to frequently asked questions in English or Spanish.

Look on the Internet:

- Visit www.medicare.gov to get more information on Medicare, order booklets, and compare health plans, Medigap policies, nursing homes, and more!

other side

Where To Get Your Medicare Questions Answered



Call the Social Security Administration (SSA)

1-800-772-1213 (English and Spanish)
TTY/TDD: 1-800-325-0778

- Ask for a replacement Medicare card.
- Change your address.
- Sign up for Medicare Part A and Part B.
- Ask questions about SSA benefits.
- Ask questions about Medicare Part A and Part B eligibility and enrollment.
- Ask Medicare premium questions.
- Find your local SSA office.
- Report a death.

Hours to Call:

- 7:00 a.m. – 7:00 p.m., Monday through Friday to speak to an English- or Spanish-speaking operator.
- 24 hours a day, 7 days a week to listen to pre-recorded information and services in English or Spanish.

Look on the Internet:

- Visit www.ssa.gov to ask for a Medicare replacement card, find your local SSA office, and get important information about SSA.

If you get benefits from the Railroad Retirement Board, call your local office at 1-800-808-0772 or visit www.rrb.gov on the Internet.



Centers For Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, \$300
Publication No. HCFA 10126
Revised April 2001

You could save up to \$600 a year in Medicare expenses. See inside for details...



**Medicare Savings
Programs**

You could save up to \$600 a year in Medicare expenses.

Follow these three
steps to find out how.



Step 1

Learn about programs that can put money back in your pocket.

There are programs that save millions of people with Medicare up to \$600 each year. States have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for people who have Medicare and limited income and resources. Many people use the extra money to help pay for living expenses or prescription drugs.

But, more than half of the people who can get this money never even apply. Are you one of them?

Step 2

Answer "YES" to three important questions.

1. Do you have Medicare "Part A," also known as hospital insurance?

Step 2 *continued*

If you're not sure, look on your red, white, and blue Medicare insurance card or call Social Security toll free at 1-800-772-1213 to ask. If you are eligible for Medicare Part A but do not have it because you cannot afford it, you should continue with question 2 because there is a program that may pay the Medicare Part A premium for you.

2. Are you an individual with a monthly income of less than \$1,273* or a couple with a monthly income of less than \$1,714*?

3. Are you an individual with savings of \$4,000 or less or a couple with savings of \$6,000 or less?

Savings include things like money in a checking or savings account, stocks, or bonds. When you're figuring out your savings, do NOT include your home, a car, burial plots, up to \$1,500 for burial expenses, furniture, or \$1,500 worth of life insurance.

* If you live in Alaska or Hawaii income limits are slightly higher. Income limits will increase slightly in 2002.

Step 3

Call to get more information.

It's very important to call if you think you qualify for any of these savings programs, even if you are not sure.

Call your nearest medical assistance office. You can find the number in the phone book under Medicaid, Social Services, Medical Assistance, Human Services, or Community Services. Or, call 1-800-MEDICARE (1-800-633-4227). When you call, ask for information on **Medicare Savings Programs**. People with hearing or speech impairments, and who use a TTY/TDD should call 1-877-486-2048.

Get the most out of Medicare by taking advantage of these programs. **Call today!**

There is also a program available that can provide insurance for children under the age of 19. Call 1-877-KIDS NOW (1-877-543-7669) for more information.

New Health Insurance Is Now Available For: ✓ Infants

✓ Children

✓ Teens

Your children or grandchildren may qualify for free or low-cost health insurance.



Does your family have health insurance? There is a new program that can help working and non-working families get health insurance for their children (ages 0-19).

Health insurance helps pay for:

- Check-ups.
- Shots that protect children from some illnesses.
- Health care for illnesses and injuries.

Don't put it off . . .

tomorrow could be the day your children or grandchildren need insurance most.

For more information call:

1-877-KIDS-NOW

(1-877-543-7669)

This is a free call.



Nuevo Seguro de Salud Disponible Ahora para: ✓ Infantes

✓ Niños

✓ Adolescentes

Sus hijos o nietos
podrán calificar
para recibir seguro
de salud gratis o
de bajo costo.



¿Dispone su familia de seguro de salud? Hay un nuevo programa que ofrece ayuda a familias con o sin trabajo para obtener seguro de salud para sus hijos (de hasta 19 años de edad).

El seguro de salud paga por:

- Chequeos.
- Inyecciones que protejen a los niños contra enfermedades.
- Cuidado de salud para enfermedades o lesiones.

No ignore esta oportunidad. . .
mañana puede ser el día en que sus hijos y nietos
necesiten más el seguro.

Si desea más información llame al:

1-877-KIDS-NOW

(1-877-543-7669)

Esta llamada es gratis.





Medicare and Home Health Care

This book explains . . .

- ◆ The home health benefit and who is eligible.
- ◆ What is covered by the Original Medicare Plan.
- ◆ How to find a home health agency.
- ◆ Where you can get more help.



HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

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What is Home Health Care?

Home Health Care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. This booklet explains Medicare's home health benefit and gives you information about where to get more information and help.

Who is Eligible for Home Health Care?

All Medicare beneficiaries can get home health care benefits, if they meet certain conditions. This booklet describes home health care benefits covered by the Original Medicare Plan. If you are in a Medicare managed care plan, see page 12.

How Can I Get Care at Home?

To get Medicare home health care you must meet these four conditions:

1. Your doctor must decide that you need medical care in your home, and make a plan for your care at home; **and**
2. You must need at least one of the following: intermittent (and not full time) skilled nursing care, **or** physical therapy **or** speech language pathology services **or** continue to need occupational therapy; **and**
3. You must be homebound. This means that you are normally unable to leave home. Being homebound means that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care, or to attend religious services; **and**
4. The home health agency caring for you must be approved by the Medicare program.

What Does the Original Medicare Plan Cover?

If you meet **all four** of the conditions above for home health care, Medicare will cover:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

The plan of care is described on page 4.

You **must** meet all four of these conditions for Medicare to cover home health care.

Medicare will cover any of these kinds of therapy for as long as you are eligible and your doctor says you need them.

- **Home health aide services** on a part-time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that support any services that the nurse provides. These services include help with personal care such as bathing, using the toilet, or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.
- **Physical therapy, speech language pathology services, and occupational therapy** for as long as your doctor says you need it. Medicare covers these types of therapy:
 - 1) **Physical therapy**, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub.
 - 2) **Speech language pathology services**, which includes exercise to regain and strengthen speech skills.
 - 3) **Occupational therapy**, which helps you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care.
- **Medical social services** to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.
- **Certain medical supplies**, like wound dressings, but not prescription drugs.
- **Medical equipment**, Medicare usually pays 80 percent of the approved amount for certain pieces of medical equipment, such as a wheelchair or walker.

Medicare and Home Health Care

The Original Medicare Plan covers these home health care services:

| Medicare Services | Covered |
|---|---------|
| Part-Time or Intermittent Skilled Nursing Care | ✓ |
| Part-Time or Intermittent Home Health Aide Services | ✓ |
| Physical and Occupational Therapy | ✓ |
| Speech Language Pathology Services | ✓ |
| Medical Social Services | ✓ |
| Medical Supplies (not drugs or biologicals) | ✓ |
| Durable Medical Equipment | ✓* |

*The Original Medicare Plan usually pays 80% of the approved amount for certain pieces of medical equipment. You may have to pay 20% of the approved amount for durable medical equipment. Ask your supplier "Do you accept assignment?" Assignment could save you money. For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Does your doctor or supplier accept assignment?"

What Doesn't the Original Medicare Plan Cover?

Medicare does **not** pay for the following:

- 24-hour per day care at home.
- Prescription drugs.
- Meals delivered to your home.
- Homemaker services like shopping, cleaning, and laundry.
- Personal care given by home health aides like bathing, using the toilet, or help in getting dressed when this is the **only** care you need.

Your plan of care is written just for you. It describes the care you need, who should give the care, and any special equipment and foods that you might need.

What is a Plan of Care?

A plan of care describes what kind of services and care you must get for your health problem. Your doctor will work with a home health care nurse to decide:

- What kind of services you need,
- What type of health care professional should give these services, and
- How often you will need the services.

Your plan may also include things like the kind of home medical equipment you need, what kind of special foods you need, and what your doctor expects from your treatment.

Your doctor and home health agency staff review your plan of care as often as necessary, but at least once every 60 days. If your health problems change, your plan of care will be reviewed and may change. Home health agency staff must tell your doctor right away if your health changes. You will continue to get home health care as long as you are eligible and your doctor says you need it.

Only your doctor can change your plan of care. Your home health agency cannot change your plan of care without getting your doctor's approval. You must be told of any changes in your plan of care. If you have a question about your care, you should call your doctor. If your agency changes your plan of care without your doctor's approval, you have the right to appeal. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

What Happens if I Am Not Getting the Care That I Need?

The home health agency will be careful to give you the care called for in your plan of care, without giving you extra services that have not been ordered by your doctor.

Your doctor works with the home health agency to make sure you get the care and services that you need. If you feel your medical needs are not being met, you should talk to both your doctor and the home health agency.

How Long Can I Get Home Health Services?

Medicare pays for your home health services for as long as you are eligible and your doctor says you need these services. However, the skilled nursing care and home health aide services are paid for only on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services.

To decide whether or not you are eligible for home health care, Medicare defines "intermittent" as:

- Skilled nursing care that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less).

Intermittent means you need home health care for a fairly short period of time.

Your doctor can increase the number of hours per week you receive care.

For example, Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The total time that the nurse will be at Jane's house will be less than an hour each day, and Jane only needs the nurse to come for 15 days. Jane's need for home health care meets the Medicare definition of "intermittent."

Hour and day limits can be increased in special cases when the need for more care is limited and can be planned ahead.

Once you are getting home health care, Medicare uses the following definition of part-time or intermittent to make decisions about your coverage:

- Skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week.

For example, Fred has been getting home health care for 3 weeks. Fred's condition is improved, but his doctor would like Fred to continue to get home health care. Fred's doctor says that he needs a nurse to come in 3 days a week for 2 hours each day (a total of 6 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 21 hours of home care per week, which meets Medicare's definition of "part-time or intermittent" home health care.

How Can Medicaid Help People with Low Incomes?

Medicaid is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. To qualify for Medicaid, you must have a low income and few savings or other assets.

Medicaid coverage differs from state to state. In all states, Medicaid pays for basic home health care and medical equipment. Medicaid may pay for homemaker, personal care, and other services that are not paid for by Medicare. Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income.

For more information about what Medicaid covers for home health care in your state, call your State medical assistance office. If you need the telephone number for your State, call 1-800-MEDICARE (1-800-633-4227 TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

What Does Medicare Pay For and What Can I Be Billed For?

Medicare pays the full approved cost of all covered home health visits. The home health agency sends bills to Medicare.

Before your care begins, the home health agency must tell you how much of your bill Medicare will pay. The agency must also tell you if any items or services they give you are not covered by Medicare, and how much you will have to pay for them. This must be explained both by talking with you and in writing.

You may be charged for:

- Medical services and supplies that Medicare does not pay for, such as prescription drugs.
- 20 percent coinsurance for Medicare covered medical equipment such as wheelchairs, walkers, and oxygen equipment. If the home health agency doesn't supply medical equipment directly, they will arrange for a home equipment supplier to get you the items you need.

The home health agency must tell you how much of your bill will be paid by Medicare.

If you are in the Original Medicare Plan, ask your supplier "Do you accept assignment?" Assignment could save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Does your doctor or supplier accept 'assignment?'"

You are protected when your home health care ends.

How Does Medicare Pay for my Home Health Care?

Medicare pays your home health agency a set amount of money for each 60 days that you need care. (This 60 day period is called an "episode of care.") The payment is based on what kind of health care an average person in your situation would need. Medicare has paid hospitals in this way for many years.

What Do I Do if Medicare Stops Paying for my Home Health Care?

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you get this notice and your doctor believes you still need home health care and that Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you must:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Understand you may have to pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical equipment.

What Do I Do if Medicare is Not Paying for an Item or Service that I Feel Should be Paid for?

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

How Do I Find an Approved Home Health Agency?

You can find a Medicare approved home health agency by:

- Asking your doctor or hospital discharge planner.
- Using a senior community referral service, or other community agencies who help you with your health care.
- Looking in your telephone directory in the Yellow Pages under “home care” or “home health care.” (Look for home health care agencies that are Medicare approved.)

If your doctor decides you need home health care, you have the right to choose the home health agency to give you needed care and services. Your choice should be honored by your doctor, hospital discharge planner or other referring agency. Some hospitals have their own home health agency. You do not have to choose the hospital’s agency. You may choose any agency that you feel will meet your medical needs.

It is important to remember that Medicare only pays for home health services that are given by a home health agency that meets Medicare's quality standards and is approved by Medicare. Medicare regularly inspects home health agencies to make sure that these standards are met.

Your home health agency must provide you with **all** the home care you need, both staff and medical supplies. The agency may do this through their own staff, through an arrangement with another agency, or they may hire someone else to meet your needs. This includes nurses, therapists, home health aides, and medical social service counselors (see pages 1 and 2).

When you start getting home care, Medicare approved home health agencies will ask you a set of questions about your health to help them give you proper care. The home health agency is required to keep this information confidential. You may ask to see this information. The home health agency will explain these questions to you, and give you written information about them.

Most home health agencies accept all Medicare patients. An agency is not required to accept you as a patient if they feel they cannot meet your medical needs. An agency cannot refuse to take you as a patient because of your condition, unless the agency also refuses to take other people with the same condition.

What Questions Do I Ask When I Choose a Home Health Agency?

Before you choose your home health agency, ask these important questions:

- Is the agency Medicare approved?
- How long has the agency been serving the community?
- Does this agency give the services I need?

- How are emergencies handled?
- Is the agency's staff on duty 24 hours a day, seven days a week?
- What will I be charged for services/supplies?
- Will Medicare or Medicaid pay for the items I need?
- How are my rights protected?
- Can my family and I help decide my plan of care?
- Does the agency teach family members about the type of care being given?
- Who makes sure that the home health care plan is being followed? Does the supervisor make regular visits to the home?
- Who can I call if I have questions or complaints?
- What happens if a home health agency staff person does not come when scheduled?
- Will the agency be in regular contact with my doctor?

What if I Want to Change Home Health Agencies?

Medicare will only pay for you to get care from one home health agency at a time. You may choose to end your relationship with one agency and choose another at any time. You must tell both the agency you are leaving and the new agency that you choose that you are changing home health agencies.

What if I am in a Managed Care Plan?

Medicare managed care plans are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Medicare managed care plans must cover all Medicare Part A and Part B health care, including home health care.

If you belong to a Medicare managed care plan, you can only choose a home health agency that works with the managed care plan. Call your managed care plan if you have questions about the plan's home health care rules, coverage, appeal rights, and your costs. If you get services from a doctor or a home health care agency that doesn't work with the managed care plan, neither the plan nor Medicare will pay the bill. If you are not sure if you are in a Medicare managed care plan, you can call your local Social Security Administration (SSA) office, or call SSA at 1-800-772-1213. If you would like more information about Medicare managed care plans, call 1-800-MEDICARE (1-800-633-4227).

A counselor in your State Health Insurance Assistance Program can help answer your questions.

Where Can I Get Help with My Questions?

If you have questions about your Medicare home health care and you are in the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 15 and 16). If you have questions about home health care and you are in a Medicare managed care plan, call your plan. If you are covered by another kind of supplemental insurance plan, call the plan's member services office.

Every State, territory, plus Puerto Rico, the Virgin Islands, and the District of Columbia, has a State Health Insurance Assistance Program (see pages 17-22) with counselors who will give you free health insurance information and help.

The counselors should be able to answer your questions about home health care and what Medicare, Medicaid, and other types of insurance pay for. In addition, these counselors will help you with Medicare payment questions; questions on buying a Medigap policy, or long-term care insurance; dealing with payment denials and appeals; Medicare rights and protections; sending complaints about your care or treatment; or choosing a Medicare health plan. You can find the phone number for your State Health Insurance Assistance Program on pages 17-22.

How Do I Complain About the Quality of My Care?

If you believe that the home health agency is not giving you good quality care, or you have a complaint about your home health agency, you should call your state home health hotline (see pages 17-22). Your home health agency should give you this number when you start getting home health services. Or you can call the Peer Review Organization (PRO) in your state to file a complaint (see pages 17-22).

How Do I Find and Report Fraud?

Most home health agencies are honest, and use correct billing information. Unfortunately, fraud occurs in the home health industry. It wastes Medicare dollars and takes money used to pay claims. You are important in the fight to prevent fraud, waste, and abuse in the Medicare program.

The best way to protect your home health benefit is to know what Medicare covers, and to know what your doctor has planned for you. If you do not understand something in your plan of care, ask questions.

You are important in fighting Medicare fraud.

Medicare and Home Health Care

To report Medicare fraud, call
1-800-447-TIPS
(1-800-447-8477).

You should look for:

- Home health visits that your doctor orders that you never get.
- Visits by home health staff that are not needed.
- Bills for services and equipment you never get.
- Faking your signature or your doctor's signature.
- Pressure to accept items and services that you do not need.
- Items listed on your Medicare Summary Notice or Explanation of Medicare Benefits that you do not think you received.

You also should be careful about activities such as:

- Home health services your doctor did not order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free, but they need your number for their records.

To report any suspected home health care fraud, call the Regional Home Health Intermediary for your state (see pages 15 and 16), or call 1-800-447-TIPS (1-800-447-8477). Each call is taken seriously.

Important Telephone Numbers

The following pages have telephone numbers that you can use if you need more information.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to www.medicare.gov on the Internet and select "Helpful Contacts".

Medicare and Home Health Care

Regional Home Health Intermediary (RHHI): Call about home health care, hospice care, and fraud and abuse.

| If you live in: | Your Regional Home Health Intermediary is: |
|------------------------|---|
| Connecticut | Associated Hospital Service Of Maine |
| Maine | 1(888)896-4997 |
| Massachusetts | 1(207)822-4646 |
| New Hampshire | |
| Rhode Island | |
| Vermont | |

| If you live in: | Your Regional Home Health Intermediary is: |
|--------------------------|---|
| Alaska | Blue Cross Of California Medicare |
| American Samoa | 1(805)383-2990 |
| Arizona | |
| California | |
| Guam | |
| Idaho | |
| Nevada | |
| Northern Mariana Islands | |
| Oregon | |
| Washington | |

| If you live in: | Your Regional Home Health Intermediary is: |
|------------------------|---|
| Hawaii | Blue Cross of California Medicare |
| | 1(808)942-2400 |

Medicare and Home Health Care

Regional Home Health Intermediary (RHHI): Call about home health care, hospice care, and fraud and abuse.

If you live in:

| | |
|-----------|----------------|
| Alabama | Mississippi |
| Arkansas | New Mexico |
| Florida | North Carolina |
| Georgia | Ohio |
| Illinois | Oklahoma |
| Indiana | South Carolina |
| Kentucky | Tennessee |
| Louisiana | Texas |

Your Regional Home Health Intermediary is:

Palmetto Government Benefits Administration
1(800)583-2236
1(803)935-0147 TTY/TDD

If you live in:

Michigan
Minnesota
New Jersey
New York
Puerto Rico
Virgin Islands
Wisconsin

Your Regional Home Health Intermediary is:

United Government Services
1(414)224-4954
1(800)722-8140 TTY/TDD

If you live in:

| | |
|----------|-----------------|
| Colorado | North Dakota |
| Delaware | Pennsylvania |
| Iowa | South Dakota |
| Kansas | Utah |
| Maryland | Virginia |
| Missouri | Washington D.C. |
| Montana | West Virginia |
| Nebraska | Wyoming |

Your Regional Home Health Intermediary is:

Cahaba Health Benefits Administration
1(877)910-8139

Medicare and Home Health Care

| State | State Health Insurance Assistance Program (SHIP): Call about Medicare plan choices, help with filing an appeal, and supplement insurance policies (Medigap) | Peer Review Organization (PRO): Call about quality of care complaints and filing an appeal or complaint | State Home Health Hotline (SHHHL): Call if you believe your home health agency is not giving you good quality care, or you have a complaint about your home health agency |
|----------------|---|--|---|
| Alabama | 1(800)243-5463 | Alabama Quality Assurance Foundation 1(800)760-3540 | 1(800)-356-9596 in-state calls only |
| Alaska | 1(907)269-3680 1(907)269-3691 TTY/TDD | PRO West 1(800)445-6941 1(800)251-8890 TTY/TDD | 1(888)-387-9387 in-state calls only |
| American Samoa | 1(888)875-9229 Government of American Samoa | Mountain Pacific Quality Health Foundation 1(800)524-6550 | |
| Arizona | 1(800)432-4040 1(602)542-6366 TTY/TDD | Health Services Advisory Group 1(800)359-9909 | 1(800)-221-9968 in-state calls only |
| Arkansas | 1(800)224-6330 | Arkansas Foundation for Medical Care, Inc. 1(800)272-5528 | 1(800)-223-0340 |

Medicare and Home Health Care

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|-------------|---|---|--|
| California | 1(800)434-0222 | California Medical Review 1(800)841-1602 1(800)881-5980 TTY/TDD | Los Angeles County 1(800)-228-1019 Berkeley 1(800)-554-0352 Chico 1(800)-554-0350 Daly City 1(800)-554-0353 Fresno 1(800)-554-0351 Orange County 1(800)-228-5234 Riverside 1(888)-354-9203 Sacramento 1(800)-554-0354 San Bernardino 1(800)-344-2896 San Diego 1(800)-824-0613 San Jose 1(800)-554-0348 |
| Colorado | 1(888)696-7213 1(303)894-7880 TTY/TDD | Colorado Foundation for Medical Care, Inc. 1(800)727-7086 1(303)695-3314 TTY/TDD | 1(800)-842-8826 in-state calls only |
| Connecticut | 1(860)424-5245 1(860)842-5424 TTY/TDD | Qualidigm 1(800)553-7590 | 1-(800)-828-9769 in-state calls only |

Medicare and Home Health Care

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|--------------|--|--|--|
| Delaware | 1(302)739-6266 | Quality Insights of Delaware 1(302)475-8100 | 1-(800)-942-7373 in-state calls only |
| Florida | 1(850)414-2060 1(850)414-2001 TTY/TDD | Florida Medical Quality Assurance, Inc. 1(800)844-0795 | 1-(888)-419-3456 |
| Georgia | 1(800)669-8387 | Georgia Medical Care Foundation 1(800)979-7217 | 1-(800)-326-0291 |
| Guam | 1(888)875-9229 | Mountain Pacific Quality Health Foundation | |
| Hawaii | 1(888)875-9229 | Mountain Pacific Quality Health Foundation 1(800)524-6550 | 1-(800)-762-5949 |
| Idaho | 1(208)334-4350 1(800)377-3529 TTY/TDD | PRO West 1(800)445-6941 1(800)251-8890 TTY/TDD | 1-(800)-345-1453 in-state calls only |
| Illinois | 1(217)785-9021 1(217)524-4872 TTY/TDD | Illinois Foundation for Quality Health Care 1(800)647-8089 | 1-(800)-252-4343 in-state calls only |
| Indiana | 1(317)233-3475 | Health Care Excel, Inc. 1(800)288-1499 | 1-(800)-246-8909 |

Medicare and Home Health Care

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|---------------|---|---|--|
| Iowa | 1(800)351-4664 | Iowa Foundation for Medical Care, Inc. 1(800)752-7014 | 1-(800)-383-4920 |
| Kansas | 1(800)337-7386 1(877)235-3151 TTY/TDD | The Kansas Foundation For Medical Care, Inc. 1(800)432-0407 | 1-(800)-842-0078 |
| Kentucky | 1(502)564-7372 1(888)642-1137 TTY/TDD | Health Care Excel, Inc. 1(800)288-1499 | 1-(800)-635-6290 |
| Louisiana | 1(225)342-5301 | Louisiana Health Care Review, Inc. 1(225)926-6353 in-state calls only | 1-(800)-327-3419 |
| Maine | 1(207)623-1797 | Northeast Health Care Quality Foundation 1(603)749-1641 in-state calls only | 1-(800)-621-8222 in-state calls only |
| Maryland | 1(410)767-1100 1(410)767-1083 TTY/TDD | Delmarva Foundation for Medical Care 1(800)492-5811 | 1-(800)-492-6005 |
| Massachusetts | 1(617)727-7750 1(800)872-0166 TTY/TDD | Massachusetts Peer Review Organization 1(718)890-0011 in-state calls only | 1-(800)-462-5540 in-state calls only |
| Michigan | 1(800)803-7174 | Michigan Peer Review Organization, Inc. 1(800)365-5899 | 1-(800)-882-6006 |

Medicare and Home Health Care

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|---------------|--|--|---|
| Minnesota | 1(800)333-2433 1(800)627-3529 TTY/TDD | Stratis Health 1(800)444-3423 | 1-(800)-369-7994 |
| Mississippi | 1(800)948-3090 | Mississippi Foundation For Medical Care, Inc. 1(800)844-0600 | 1-(800)-227-7308 |
| Missouri | 1(800)390-3330 | Missouri Patient Care Review Foundation 1(800)347-1016 | 1-(800)-877-6485 |
| Montana | 1(406)444-7781 1(800)833-8503 TTY/TDD | Mountain Pacific Quality Health Foundation 1(800)497-8232 | 1-(800)-762-4618 in-state calls only |
| Nebraska | 1(800)234-7119 1(800)833-7352 TTY/TDD | Sunderbruch Corporation 1(800)247-3004 | 1-(800)-245-5832 in-state calls only |
| Nevada | 1(800)307-4444 | Healthinsight 1(800)748-6773 | 1-(800)-225-3414 |
| New Hampshire | 1(603)225-9000 | Northeast Health Care Quality Foundation 1(603)749-1641 | 1-(800)-621-6232 in-state calls only |
| New Jersey | 1(609)588-3139 | The Peer Review Organization of New Jersey, Inc. 1(732)238-5570 | 1-(800)-792-9770 in-state calls only |
| New Mexico | 1(505)827-7640 | New Mexico Medical Review Association 1(800)279-6824 | 1-(800)-752-8649 in-state calls only |

Medicare and Home Health Care

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|--------------------------|---|---|---|
| New York | 1(800)333-4114 | Island Peer Review Organization - IPRO 1(800)331-7767 | 1(800)628-5972 in-state calls only |
| North Carolina | 1(919)733-0111 | Medical Review Of North Carolina 1(800)722-0468 | 1-(800)-624-3004 in-state calls only |
| North Dakota | 1(800)247-0560 1(800)366-6888 TTY/TDD | North Dakota Health Care Review, Inc. 1(701)852-4231 | 1-(800)-545-8256 in-state calls only |
| Northern Mariana Islands | 1(888)875-9229 | Mountain Pacific Quality Health Foundation 1(800)524-6550 | |
| Ohio | 1(800)686-1578 | Ohio KePRO, Inc. 1(800)589-7337 | 1-(800)-342-0553 in-state calls only |
| Oklahoma | 1(405)521-6628 | Oklahoma Foundation For Medical Quality, Inc. 1(405)840-2891 | 1-(800)-234-7258 in-state calls only |
| Oregon | 1(503)947-7984 1(503)947-7280 TTY/TDD | Oregon Medical Professional Review Organization 1(800)344-4354 | 1-(800)-542-5186 in-state calls only |
| Pennsylvania | 1(800)783-7067 | Keystone Peer Review Organization-KEPRO 1(800)322-1914 | 1-(800)-222-0989 in-state calls only |
| Puerto Rico | 1(877)725-4300 | Quality Improvement Professional Research Organization 1(787)641-1240 | |

Medicare and Home Health Care

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|----------------|--|--|--|
| Rhode Island | 1(401)222-2880 | Rhode Island Quality Partners, Inc. 1(800)662-5028 | 1-(800)-228-2716 in-state calls only |
| South Carolina | 1(803)898-2850 | Carolina Medical Review 1(803)731-8225 | 1-(800)-624-3004 in-state calls only |
| South Dakota | 1(605)773-3656 1(800)642-6410 TTY/TDD | South Dakota Foundation for Medical Care, Inc. 1(800)658-2285 | 1-(800)-922-6735 in-state calls only |
| Tennessee | 1(800)525-2816 | Mid South Foundation For Medical Care, Inc. 1(800)489-4633 | 1(800)541-7367 |
| Texas | 1(800)252-9240 | Texas Medical Foundation 1(800)725-8315 1(800)725-8339 TTY/TDD | 1(800)228-1570 in-state calls only |
| Utah | 1(801)538-3910 | Healthinsight 1(800)274-2290 | 1-(800)-999-7339 in-state calls only |
| Vermont | 1(802)748-5182 | Northeast Health Care Quality Foundation 1(603)749-1641 | 1-(800)564-1612 in-state calls only |
| Virgin Islands | 1(304)778-6311 ext. 2238 | Virgin Island Medical Institue, Inc. 1(304)712-2400 | |

Medicare and Home Health Care

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|-----------------|--|--|---|
| Virginia | 1(800)552-3402 | Virginia Health Quality Center 1(804)289-5304 1(800)828-1140 TTY/TDD | 1(800)995-1819 in-state calls only |
| Washington | 1(800)397-4422 1(360)407-0409 TTY/TDD | Pro West 1(800)445-6941 1(800)251-8890 TTY/TDD | 1(800)663-6828 in-state calls only |
| Washington D.C. | 1(202)739-0668 1(202)973-1079 TTY/TDD | Delmarva Foundation for Medical Care 1(800)645-0011 | 1(202)442-5833 |
| West Virginia | 1(877)987-4463 | West Virginia Medical Institute, Inc. 1(800)642-8686 ext.2266 | 1(800)442-2888 in-state calls only |
| Wisconsin | 1(800)242-1060 | MetaStar 1(800)362-2320 | 1(800)642-6552 in-state calls only |
| Wyoming | 1(800)856-4398 | Mountain Pacific Quality Health Foundation 1(800)497-8232 | 1(800)548-1367 in-state calls only |

Definitions of Important Terms

Appeal: An appeal is a special kind of complaint you make if you disagree with a decision about your health care services. For example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Approved Amount: The fee Medicare sets as reasonable for a covered medical service. It may be less than the actual amount charged. Approved amount is sometimes called "approved charge."

Durable Medical Equipment: Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Homebound: Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for nonmedical reasons, such as a trip to the barber, or attend religious services. A need for adult day care does not keep you from getting home health care for other medical conditions.

Home Health Agency: An organization that provides home care services, including skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care: Skilled nursing care and certain other health care that you get in your home for the treatment of an illness or injury.

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes. Programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare: A health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD) (people with permanent kidney failure who need dialysis or a transplant).

Medicare Managed Care Plan: These are health care choices in some areas of the country. In most plans you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Original Medicare Plan: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amounts, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Plan Of Care: A plan written by your doctor that describes what kind of services and care you must receive for your health problem.

Definitions of Important Terms

Peer Review Organization (PRO):

Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Provider: A doctor, hospital, health care professional, or health care facility.

Regional Home Health Intermediary:

A private company that contracts with Medicare to process claims and make checks of home health care.

Skilled Nursing Care: A level of care that must be given or supervised by licensed nurses and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered.

State Health Insurance Assistance

Program (SHIP): A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries.

*This definition, whole or in part, was used with permission from Walter Feldesman, Esq., *Dictionary of Eldercare Terminology*, © 2000.

| | |
|---|--------------------|
| Appeals | 5, 9, 13 |
| Assignment | 7 |
| Durable Medical Equipment | 3, 25 |
| Eligibility | 1 |
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| Home Health Agency | 1, 5, 7, 8, 9, 25 |
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| Intermittent | 1, 5, 6 |
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| Skilled Nursing Care | 1, 3, 6, 26 |
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| State Health Insurance Assistance Program | 12, 17-24, 26 |

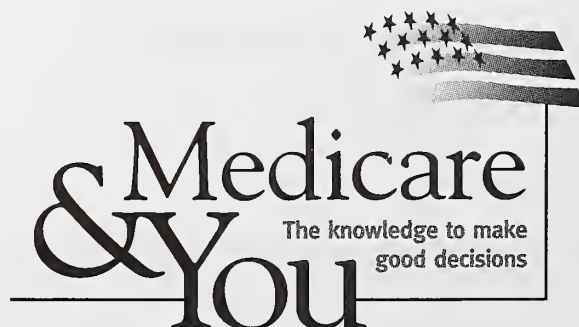
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, \$300

Publication No. HCFA-10969
Revised, November 2000

To get this booklet in Braille, Spanish, in large print (English and Spanish) or on audiotape (English or Spanish), call 1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired.



Medicare Preventive Services...

...To Help Keep You Healthy

There are steps you can take to lower your risk of disease and illness. Medicare is providing coverage for these preventive services to help you stay healthy. Medicare will cover:

- ⊕ Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer;
- ⊕ Bone mass measurements;
- ⊕ Diabetes monitoring and diabetes self-management;
- ⊕ Flu, pneumonia, and Hepatitis B shots; and
- ⊕ Prostate cancer screening tests.

These valuable benefits from Medicare may be the key to long lasting good health. Talk with your doctor about your risk of developing these health problems and your need for these preventive services.

This pamphlet includes:

- ⊕ A chart that explains which preventive services are covered by Medicare, for whom they are covered, and what you pay.
- ⊕ Cards with more detailed information on some of the preventive benefits. You can tear these out and put them on your calendar or refrigerator as a reminder, or you can take them to your doctor so that you can talk about the preventive services that Medicare covers.



Medicare Preventive Services – Added Benefits to Help

Covered Service

Bone Mass Measurements:

Varies with your health status.

Colorectal Cancer Screening:

- **Fecal Occult Blood Test** - Once every 12 months.
- **Flexible Sigmoidoscopy** - Once every 48 months.
- **Colonoscopy** - Once every 24 months if you are at high risk for colon cancer. Starting July 1, 2001, once every 10 years but not within 48 months of a screening sigmoidoscopy if you are not at high risk for colon cancer.
- **Barium Enema** - Doctor can decide to use instead of a sigmoidoscopy or colonoscopy.

Diabetes Services:

- Coverage for glucose monitors, test strips, and lancets.
- Diabetes self-management training.

Mammogram Screening:

Once every 12 months. Medicare also covers new digital technologies for mammogram screenings.

Pap Smear and Pelvic Examination:

(Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months. Starting July 1, 2001, Pap smear and pelvic examinations are covered once every 24 months.

Prostate Cancer Screening:

- **Digital Rectal Examination** - Once every 12 months.
- **Prostate Specific Antigen (PSA) Test** - Once every 12 months.

Shots (Vaccinations):

- **Flu Shot** - Once a year in the fall or winter.
- **Pneumococcal Pneumonia Shot** - One shot may be all you will ever need. Ask your doctor.
- **Hepatitis B Shot** - If you are at medium to high risk for hepatitis.

Glaucoma Screening:

Starting January 1, 2002, once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.

You Stay Healthy

| Who is Covered | What You Pay |
|---|--|
| Certain people with Medicare who are at risk for losing bone mass. | 20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B deductible. |
| All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy. | <p>Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.</p> <p>For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.</p> |
| <ul style="list-style-type: none"> • All people with Medicare who have diabetes (insulin users and non-users). • If requested by your doctor or other provider and you are at risk for complications from diabetes. | <ul style="list-style-type: none"> • 20% of the Medicare-approved amount after the yearly Part B deductible. • 20% of the Medicare-approved amount after the yearly Part B deductible. |
| All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39. | 20% of the Medicare-approved amount with no Part B deductible. |
| All women with Medicare. | Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible. |
| All men with Medicare age 50 and older. | Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test. |
| All people with Medicare. | Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible. |
| People at high risk for glaucoma, including people with diabetes or a history of glaucoma. | 20% of the Medicare-approved amount after the yearly Part B deductible. |

Medicare Preventive Services

Colorectal Cancer Screening

Which colorectal screening benefits are covered under Medicare?

Medicare covers:

- ⊕ A screening fecal occult blood test (FOBT),
- ⊕ Flexible sigmoidoscopy,
- ⊕ Screening colonoscopy, and
- ⊕ Barium Enema.

The FOBT and the flexible sigmoidoscopy are considered to be general preventive screenings. However, if you are at high risk for colorectal cancer, Medicare will cover a screening colonoscopy. Medicare also covers a barium enema if your doctor decides to use a barium enema instead of a flexible sigmoidoscopy or screening colonoscopy. *(over)*

Call 1-800-4CANCER or visit
www.nci.nih.gov for more health
information.



Medicare Preventive Services

Mammography Screening

Which breast cancer screening benefits are covered under Medicare? How often are they covered?

Medicare will pay for a mammogram every 12 months. Regular mammography screenings can save your life. Medicare also covers new digital technologies for mammogram screenings.

Who is eligible to receive a mammography screening?

All women with Medicare age 40 and older are eligible for mammography screenings every 12 months. Medicare also pays for one baseline mammogram for female Medicare beneficiaries between ages 35 and 39. *(over)*

Call 1-800-4CANCER or visit
www.nci.nih.gov for more health
information.



Medicare Preventive Services

Flu, Pneumococcal Pneumonia, and Hepatitis B Shots (Vaccinations)

Which preventive shots are covered by Medicare?

Flu shots, pneumococcal pneumonia shots, and Hepatitis B shots are covered by Medicare. Flu, pneumonia, and hepatitis can be life threatening to the elderly.

Who is eligible to receive these shots?

All people with Medicare are eligible for flu shots and pneumonia shots. Hepatitis B shots are covered only for persons at medium to high risk for hepatitis. *(over)*

Call 1-800-MEDICARE or visit
www.medicare.gov for more
health information.



Medicare Preventive Services

Pap Smear and Pelvic Exam (Includes Clinical Breast Exam)

Does Medicare cover screenings to find cervical and vaginal cancers?

Medicare covers Pap smears and pelvic exams to check for cervical and vaginal cancers. In addition to the pelvic exam, a clinical breast exam is covered to check for breast cancer.

Who is eligible to receive Pap smears and pelvic exams?

All women with Medicare are eligible. *(over)*

Call 1-800-4CANCER or visit
www.nci.nih.gov for more health
information.



Mammography Screening—continued

Am I at high risk for breast cancer?

Simply getting older increases breast cancer risk. The older you are, the greater your chance of getting breast cancer. However, several factors that could place you at higher risk include:

- ⊕ If you had breast cancer before;
- ⊕ If you have a family history of breast cancer—that is, a mother, sister, daughter or two or more close relatives who had breast cancer; or
- ⊕ If you had your first baby after the age of 30, or if you never have had a baby.

How do I get more information about breast cancer and mammography screening?

Discuss your breast cancer risk and screening with your doctor, or call the National Cancer Institute at 1-800-4-CANCER or visit www.nci.nih.gov for more information.

Pap Smear and Pelvic Exam—continued

How often will Medicare cover a Pap smear and pelvic exam?

A Pap smear and pelvic exam are covered by Medicare once every 36 months. However, if you are a woman of childbearing age and have had an abnormal Pap smear within the preceding 36 months, or you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap smear and pelvic exam every 12 months. Starting July 1, 2001, Pap smears and pelvic examinations are covered once every 24 months.

Who is at high risk for cervical or vaginal cancer?

Risk for cervical cancer is increased if you have had an abnormal Pap test, if you have had cancer before, or if you have been infected with the human papilloma viruses (HPVs). If you began having sexual intercourse before the age of 16, or if you have had many sexual partners, you also have a greater cervical cancer risk. Risk for vaginal cancer is increased for daughters of women who took DES during pregnancy.

Colorectal Cancer Screening—continued

Who is eligible to get a colorectal screening?

All people with Medicare age 50 and older are eligible for colorectal screenings. However, there is no minimum age for having a colonoscopy.

How often will Medicare cover colorectal exams?

A fecal occult blood test is covered once every 12 months and a sigmoidoscopy once every 48 months. If you are at high risk for colorectal cancer, Medicare covers a colonoscopy every 24 months. Starting July 1, 2001, Medicare covers a colonoscopy once every 10 years, but not within 48 months of a screening sigmoidoscopy if you are not at high risk for colon cancer. A doctor can decide to use a barium enema instead of a sigmoidoscopy or colonoscopy.

Who is at high risk for colorectal cancer?

After age 40, colorectal cancer risk increases with age. Your risk is greater if you or a family member has a history of colorectal cancer, inflammatory bowel disease, polyps, or certain hereditary syndromes.

Flu, Pneumococcal Pneumonia and Hepatitis B Shots—continued

How often will Medicare cover these shots?

Medicare pays for a flu shot once a year in the fall or winter. Medicare will also pay for a pneumonia shot, which you should get by age 65. Most people only need to get this shot once in their lifetime. Medicare will pay for a Hepatitis B shot if you are at medium to high risk for hepatitis.

Who is at risk for flu, pneumonia, or Hepatitis B?

Flu and pneumonia infections can be life-threatening for elderly people. All adults 65 and older should get flu and pneumonia shots. Those at medium to high risk for Hepatitis B include individuals with End-Stage Renal Disease or hemophilia.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

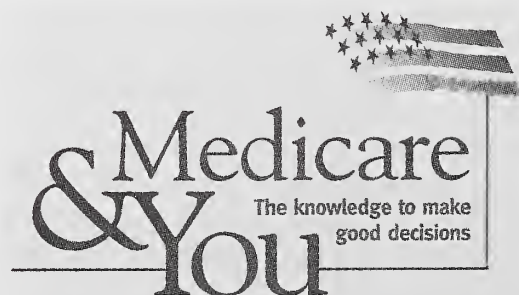
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(TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Para obtener este folleto en inglés, español o chino, llame gratis al 1-800-633-4227
(TTY/TDD: 1-877-486-2048 para personas con impedimentos auditivos o del
lenguaje oral).



Medicare.gov

The Official U.S. Government Site for People with Medicare

Medicare.gov has useful information for people with Medicare and those who help them make health care decisions. The most frequently used topics are:

★ **Search Tools**

Search for information on health plans, nursing homes, dialysis facilities, Medigap policies, participating physicians and suppliers, and phone contacts, and Medicare activities in your area.

★ **Medicare Basics**

Get information on coverage, eligibility, enrollment, your Medicare card, address changes, and help with health care costs.

★ **Medicare Plan Choices**

Learn about the Original Medicare Plan, Medicare + Choice Plans (managed care plans and Private Fee-for-Service plans), and Medigap policies. You can also compare health plans available in your area.

★ **Nursing Homes**

Get information on payment, patient rights, and alternatives to nursing homes. You can also compare nursing homes in your area and use the checklist to narrow down your choices.

★ **Helpful Contacts**

Find phone numbers and websites for help in answering your questions.

★ **Publications**

Look at, order, or download Medicare and health-related publications.

★ **Fraud and Abuse**

Learn how to recognize and prevent fraud and abuse.

★ **Health Information**

Get important information and links to health websites to help you stay healthy.



Reaching More People with Medicare:

- Medicare information is available in Spanish and Chinese.
- "Screen Reader" technology allows people with low vision or blindness to have quick, reliable access to the information they need.
- Easy print format allows visitors to print all pages within each section without links and extra text.
- The Frequently Asked Questions section allows visitors to search by category or phrase to quickly find answers to their questions. If visitors are unable to find answers, they can submit questions. This section also includes a subscription service, which notifies users when questions are updated.

Seniors are Surfing the Web

More and more, people with Medicare and those who will soon be eligible for Medicare use the Internet. Research shows that Internet use is growing among people age 50 and older:

- Internet access among people with Medicare has increased dramatically from 1997 to 2001. Findings from the CMS-sponsored Medicare Current Beneficiary Survey indicate that the percentage of people with Medicare reporting access to the Internet climbed from 6.8% in 1997 to 31% in 2001.

Search Tools to Find Local Medicare Information

Medicare Personal Plan Finder

Answer simple questions and get a personalized health plan summary page with information to help you compare health plans in your area and narrow down your choices.

Nursing Home Compare

Compare nursing homes in your area by looking at nursing homes characteristics, state inspection results, and nursing staff information.

Prescription Drug Assistance Programs

Get information about programs that offer discounts or free medication to individuals in need.

Participating Physician Directory

Find Medicare participating physicians in your area.

Participating Supplier Directory

Find Medicare participating suppliers in your area.

Local Medicare Events

Get details about events on Medicare-related topics in your area, and information about how you can attend.

Dialysis Facility Compare

Compare dialysis facilities in your area by looking at quality and center characteristics.

Medicare Health Plan Compare

Shop for health plans by comparing costs, benefits, quality, and plan member disenrollment rates.

Medigap Compare

Find supplemental insurance policies available in your area to cover expenses not paid for by the Original Medicare Plan.

New Rules for Switching Medicare Health Plans



This booklet is for you if:

- You are in a Medicare managed care plan (like an HMO) or Medicare Private Fee-for-Service plan now, or
- You are thinking about joining one of these plans.

CENTERS FOR MEDICARE & MEDICAID SERVICES



Disclaimer: This booklet provides a summary of Medicare plan changes. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

How to find what you need in this booklet:

If you:

Turn to page(s):

Want to find out about the new rules2

Want to know what the rules are now3

Want to know why the rules are changing3

Want to know if there are exceptions to the
new rules3-4

Want to know how the new rules will affect
your costs4

Want to know if your doctor can change plans4

Are 65 and new to Medicare5

Are not new to Medicare, but this is the first time
you are eligible to join a Medicare health plan6

Are not sure how these new rules affect you7

Have employer or union health coverage7

Want information on other Medicare topics7

Want to know what a word in this booklet means8
(Words in blue are defined here)

The Rules for Switching Medicare Health Plans are Changing

Over the next two years, the rules for when and how often you can switch Medicare health plans will change. If you are in a Medicare health plan or are thinking about joining one, you need to know how the new rules affect you. The new rules are:

Starting January 1, 2002, you can leave a Medicare health plan and join another plan **only one time** from **January 1** through **June 30, 2002**. The plan must be accepting new members.

Medicare Health

Plan: These are different types of health plans for people with Medicare including the Original Medicare Plan, Medicare managed care plans (like HMOs), and Medicare Private Fee-for-Service plans.

In November of 2002, you will have another chance to switch plans. If you switch plans in November 2002, the change will be effective January 1, 2003.

Starting January 1, 2003, the rules will change. You can leave a Medicare health plan and join another plan **only one time** from **January 1** through **March 31, 2003**. The plan must be accepting new members.

Just like in 2002, you will have another chance to switch plans in **November**. Any change made in November will be effective the following January.

There are some exceptions to these new rules. You may also have specific questions or concerns. The rest of this booklet will explain the new rules in more detail.

What are the old rules for leaving a Medicare health plan?

Until December 31, 2001, you can leave a Medicare health plan at any time for any reason. You can join a Medicare health plan at any time as long as the plan is accepting new Medicare members. You do not have to stay in the plan for any specific period of time. You can also leave a Medicare managed care plan or Private Fee-for-Service plan and join the Original Medicare Plan at any time.

Why are the rules changing?

Congress decided in 1997, that Medicare health plans should have certain times when people can make changes. The new rules will make Medicare like most other health insurance programs, which allow people to change health plans only during certain times of the year. These rules will help Medicare health plans manage health care costs and payments, and plan for your care.

Is there any time of year when I can change plans, no matter what?

Anyone can change Medicare health plans from November 1 to November 30 every year. During the month of November you can leave any Medicare health plan. You can join another plan, if it is accepting new Medicare members. Or, you can return to the Original Medicare Plan. Any change made in November will be effective the following January.

Are there any times when the new rules do not apply?

There are a few times when the new rules for the year 2002 and beyond do not apply. You could leave or join a Medicare health plan at another time if:

1. Your health plan leaves Medicare.
2. You move out of your plan's service area.
3. You are in another situation that Medicare decides is an exception.

Once I am in a plan, how do I know the plan will not increase my costs?

Once you join a plan, your premium and copayments will not increase for the year you are enrolled. If your plan increases premiums or copayments for the following year, you will get a notice by late October. You then have the option during November to switch plans or return to the Original Medicare Plan.

Your plan may be able to change the benefits it offers. For example, your plan may be able to change its drug formulary (a list of prescription drugs that the plan covers) at any time. If this happens, your plan may no longer cover medications you need or you may have to pay more out-of-pocket for prescription drug coverage.

Will my doctor be able to leave the plan at any time?

Yes. Doctors can join or leave Medicare health plans at any time. If your doctor leaves your plan, ask your plan for the names of participating doctors in your area, so you can switch to a new doctor.

Depending on your situation, different rules may apply to you. This section of the booklet talks about different rules for people who:

- ◆ Are 65 years old and new to Medicare.
- ◆ Just became eligible to join a Medicare managed care plan, or Private Fee-for-Service plan.

I'm 65 and new to Medicare. What do I need to know about the new rules for joining and leaving a health plan?

Different rules apply to you if you are 65 and new to Medicare.

Beginning in 2002, you can leave the first Medicare health plan you joined (when you turned 65) and return to the Original Medicare Plan once during your **first 12 months in that plan**.

You also have an opportunity to switch to a new Medicare managed care plan (like an HMO) or Private Fee-for-Service plan.

- ◆ In 2002, you can make one switch to a Medicare managed care plan or Private Fee-for-Service plan during the first six months after you begin to get Medicare benefits.
- ◆ In 2003, you will be able to make this type of change during the first three months after you begin to get Medicare benefits.

If you make a switch and are unhappy with your change, you can switch plans again in November. When you switch plans in November, the change will be effective the following January (see page 2).

Example: Mrs. Smith turned 65 in March 2002 and received her red, white, and blue Medicare card. Her card shows that she has Medicare Part A and Part B. She joins Alpha health plan in March 2002. Mrs. Smith has until March 2003 to switch to the Original Medicare Plan. She has until August 2002 to switch to a Medicare managed care plan or Private Fee-for-Service plan.

This is the first time I'm eligible to join a Medicare managed care plan or Private Fee-for-Service plan. What do I need to know about the new rules for switching health plans?

Different rules apply to you if this is the first time you are eligible to join a Medicare managed care plan or Private Fee-for-Service plan. You may have just become eligible if you had either Medicare Part A only or Part B only and recently enrolled in both.

If **2002** is the first time you are eligible to join a Medicare managed care plan or Private Fee-for-Service plan, you can make **one switch** to another health plan or return to the Original Medicare Plan:

- ◆ During the first **six months** you are eligible to join, or
- ◆ Until December 31 of that year.
— whichever comes sooner.

Example: Mrs. Smith is eligible to join a Medicare health plan for the first time in February 2002. She joins Alpha health plan at that time. She has until July 31, 2002, to return to the Original Medicare Plan or join a different health plan.

If **2003, or any year after**, is the first time you are eligible to join a Medicare managed care plan or Private Fee-for-Service plan, you can make **one switch** to a different health plan or return to the Original Medicare Plan:

- ◆ During the first **three months** you are eligible to join, or
- ◆ Until December 31 of that year.
— whichever comes sooner.

Example: Mr. Jones is eligible to join a Medicare health plan for the first time in January 2003. He decides to join Beta health plan in March 2003. He will have to wait until November 2003 to join another health plan.

What if I don't know which group I'm in or how the new rules affect me?

If you are in a Medicare health plan and don't know how the new rules will affect you, talk to your plan representative or membership office. You also can call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048) with general questions about the new rules.

I have a Medicare health plan through my former employer/union. How will the new rules affect me?

If you have employer or union health coverage, these rules will probably not apply to you. Talk to your employer or union benefits administrator to find out if the new rules affect you.

How can I find information on other Medicare topics?

To find information on other Medicare topics, you can:

1. Look at **www.medicare.gov** on the Web and select "Publications." You can read, print, or order these booklets.
2. Call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048) to order Medicare booklets.
3. Put your name on the Web mailing list to get an e-mail message when a new Medicare booklet is available. To sign up, go to **www.medicare.gov** and select "Subscribe to Our Mailing List." Then select the topic "Publications," type your e-mail address in the box at the bottom, and select "Subscribe."

Important Words

Copayment: In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Enrollment Period: A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Medicare Managed Care Plan: These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Original Medicare Plan: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Private Fee-for-Service Plan: A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

Formerly the Health Care Financing Administration

7500 Security Boulevard

Baltimore, Maryland 21244-1850

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DEPARTMENT OF
HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Library Director,

The Public Library Association and the Centers for Medicare & Medicaid Services are pleased to provide you with the 2002 Library Edition of Medicare & You.

Today's Medicare is about choice, and this resource is designed to provide valuable information to support informed decision-making among people with Medicare. Please make sure this publication is available for your patrons, especially seniors and those who care about them.

More and more seniors have crossed the digital divide thanks to the innovative and supportive efforts of librarians like you. This publication features fresh ideas to help teach seniors more about exploring the World Wide Web using the official Medicare website, www.medicare.gov.

The Medicare website features regularly updated information about nursing homes, dialysis facilities, Medicare+Choice plans, and pharmacy assistance programs; answers to Medicare questions; and free Medicare publications to read, print out or order (most available in Spanish and some available in Chinese).

Also included in the 2002 Library Edition:

- valuable information contacts your patrons with Medicare and their caregivers can use
- publications such as the 2002 Medicare & You Handbook

The Library Edition of Medicare & You is provided annually by the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), a part of the U.S. Department of Health and Human Services. Medicare, which covers 40 million Americans, is the nation's largest health insurance program.

Please replace any previous copies of the Library Edition currently on your shelf with this year's edition. To request additional copies of the 2002 Library Edition, call 1-800-MEDICARE (1-800-633-4227).

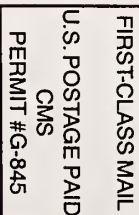


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Deputy Director
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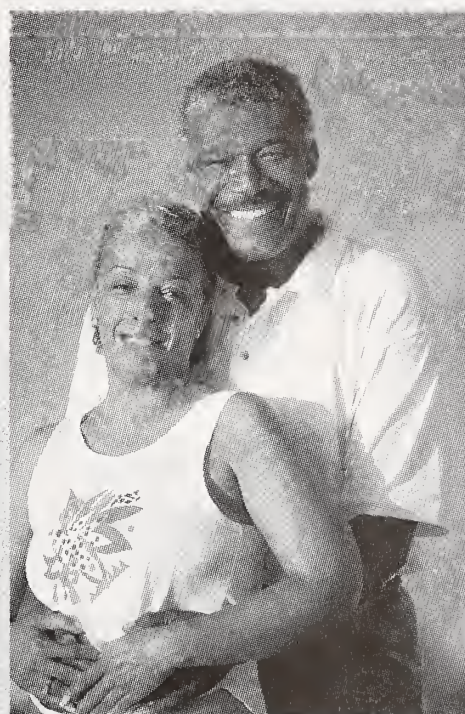
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In order to continue to receive your free copy of Medicare & You, Library Edition, go to www.hcfa.fu.com/maillinglist, (password CMS9) and register your library. You will be able to place your order for the next Library Edition as well as other free publications.





Your Medicare Rights and Protections



This booklet has important information about:

- Your right to file a complaint.
- Your right to get health care services you need.
- Where you can get help with your questions.



HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

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Note: At the time of printing, telephone numbers listed were correct. Telephone numbers sometimes change. To get the most up-to-date phone numbers, go to the web at www.medicare.gov. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

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Introduction

As a Medicare beneficiary, you have certain guaranteed rights and protections. They:

- Protect you when you get health care.
- Make sure you get the health care services that the law says you can get.
- Protect you against unethical practices.

Read this booklet so you will know about your rights and protections, and where you can get help.

How To Use This Booklet

This booklet has 8 sections. You can see which section you are reading at the top of each page. The index in Section 8 on pages 28-29 can help you find a specific topic in this booklet. Words in red are defined in Section 7 on pages 25-27.

If you have questions as you read through this booklet, write them down. Look in Section 6 on pages 22-24 to see who you can call for help with your questions. You will not find information about the benefits and costs of health plans in this booklet. If you want this information, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the health plan comparison information for your area.

Section 1: A Quick Look At Medicare (pages 3-4).

Read this section if you don't know much about Medicare. It will tell you the difference between the Original Medicare Plan, a Medicare managed care plan (like an HMO), and a Medicare Private Fee-for-Service plan. You may need to refer back to this section as you read through this booklet.

Section 2: Your Medicare Rights (pages 5-8).

Read this section to find out your rights as a Medicare beneficiary. It lists all of the rights you have no matter if you are in the Original Medicare Plan, a Medicare managed care plan (like an HMO), a Medicare Private Fee-for-Service plan, or have a Medigap (Medicare Supplement Insurance) policy.

Words in red are defined on pages 25-27.

Introduction

How To Use This Booklet (continued)

Section 3: Your Rights and Protections in the Original Medicare Plan (pages 9-15).

Read this section if you have the Original Medicare Plan, or have a Medigap (Medicare Supplement Insurance) policy. It lists specific rights for people who have this plan or policy. The rights listed in this section are in addition to the rights in Section 2.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan (pages 16-18).

Read this section if you have a Medicare managed care plan (like an HMO). It lists specific rights for people who have one of these plans. The rights listed in this section are in addition to the rights in Section 2.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan (pages 19-20).

Read this section if you have a Medicare Private Fee-for-Service plan. It lists specific rights for people who have one of these plans. The rights listed in this section are in addition to the rights in Section 2.

Section 6: For More Information (pages 21-24).

Read this section to find out how to get booklets on other Medicare topics and who you can call to get help with your questions. It lists telephone numbers to call in your state.

Section 7: Words To Know (pages 25-27).

Read this section to get the meaning of words in red used in this booklet.

Words in red are defined on pages 25-27.

Section 8: Index (pages 28-29).

Use this section if you are looking for a specific topic. It gives you the page(s) where that topic is found in this booklet.

The *Your Medicare Rights and Protections* booklet is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Section 1: A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for:

- People age 65 or older.
- Some people under age 65 with disabilities.
- People with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

What are my Medicare health plan choices?

Depending on where you live, you may be able to get your health care in one of three ways:

1. The Original Medicare Plan,
2. A Medicare managed care plan (like an HMO), or
3. A Medicare Private Fee-for-Service plan.

What is the Original Medicare Plan?

The Original Medicare Plan is also known as "fee-for-service." This plan, managed by the federal government, is available nationwide. You are usually charged a fee for each health care service or supply you get. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.

To help cover the costs the Original Medicare Plan does not cover, you may have a Medigap (Medicare Supplement Insurance) policy.

What is a Medigap policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage such as coinsurance amounts. Medigap insurance must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Words in red are defined on pages 25-27.

Section 1: A Quick Look At Medicare

What is a Medicare managed care plan?

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private companies in some areas to people with Medicare. If you have a Medicare managed care plan, you use your plan membership card when you get health care.

What is a Medicare Private Fee-for-Service plan?

A Medicare Private Fee-for-Service plan is a Medicare health plan offered by a private company. This plan is available in some areas of the country to people with Medicare. It is not the same as the Original Medicare Plan. If you have a Medicare Private Fee-for-Service plan, you use your plan membership card when you get health care.

If you want more specific information about these plans, look at www.medicare.gov on the web. Select "Publications" and choose the *Medicare & You* handbook. Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this handbook.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

If you have Medicare, you have certain guaranteed rights and protections. You have these rights whether you have the Original Medicare Plan, a Medigap policy, a Medicare managed care plan, or a Medicare Private Fee-for-Service plan. These rights include:

Respect

You have the right to be treated with dignity and respect at all times.

Protection Against Discrimination

There are laws that do not allow discrimination. Every company or agency that works with Medicare must obey the law. They cannot discriminate against you (treat you unfairly) because of your:

- Race,
- Color,
- National origin,
- Religion,
- Age, or
- Mental or physical disability.

You also have the right to have someone help you overcome a language, physical, or communication barrier.

If you think you have been discriminated against for any of these reasons, call the Office for Civil Rights in your state. The telephone number for the Office for Civil Rights in your state is in your copy of the *Medicare & You* handbook, and at www.medicare.gov on the web. Select “Helpful Contacts.” You can also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for this number.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Information

You have a right to get easy-to-understand information about Medicare to help you make decisions about your health care.

You have the right to get information about:

- What is covered.
- What costs are paid.
- How much you have to pay.
- What to do if you want to file a complaint.

You have the right to have someone help you make informed health care decisions when you need it.

You have a right to have your questions about the Medicare program answered. To get your questions answered, you can:

- Call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can get help in English or Spanish.
- Call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Emergency Care

You have a right to get emergency care when and where you need it. A medical emergency is when you think your health is in serious danger--when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

If you are in a Medicare managed care plan, you do not need to get permission from a primary care doctor before you get emergency care. If you get emergency care, you will have to pay your regular share of the cost (copayment). Then, your plan will pay its share. If your plan does not pay its share for your emergency care, you have the right to appeal (see page 7).

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Treatment Choices

You have the right to talk with your doctors about your health care and know all of your treatment choices in language that is clear to you.

You have the right to fully participate in all decisions related to your health care. If you can't fully participate, you can ask family members, friends, or anyone you trust to help you make a decision about what treatment is right for you. Medicare health plans cannot have rules that stop your doctor from telling you what you need to know about your treatment choices.

Complaints

You have the right to file a complaint about payment, services you received, other concerns or problems you have in getting health care, and the quality of the health care you received. There are two kinds of complaints: appeals and grievances.

Appeals: Billing, Payment, or Service Issues

You have the right to appeal any official decision about your Medicare services. If Medicare does not pay for a Medicare-covered item or service you have been given, does not pay enough for an item or service you have been given, or if you are not given a Medicare-covered item or service you think you should get, you can appeal. For more information on filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Grievances: Quality of Care Issues

You have a right to file a complaint if you think you are not getting quality health care. This type of complaint is called a "grievance." If you want to file a grievance about the quality of health care you have received, call the Peer Review Organization (PRO) in your state. These telephone numbers are listed on page 22.

Words in red are defined on pages 25-27.

Section 2: Your Medicare Rights

Privacy of Personal Information

You have the right to have your personal information that Medicare collects about you kept private. Medicare may collect information about you as part of its regular business, such as paying your health care bills and making sure you get quality health care. Medicare keeps the information it collects about you private. When Medicare asks for your personal information, you have the right to know why it is needed, whether it is required or optional, what happens if you don't give the information, and how it will be used.

If you want to know more about how Medicare uses your personal information, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Your state may have additional privacy laws that protect your personal information. If you want to know about the laws in your state, call your State Health Insurance Assistance Program (SHIP). These telephone numbers are listed on page 24.

Privacy of Health Information

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under federal and state laws.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or your health plan. This rule will be fully effective on April 14, 2003.

If you have any questions about this privacy rule, call the Office for Civil Rights at 1-866-OCR-PRIV (1-866-627-7748; TTY: 1-866-788-4989 for the hearing and speech impaired). Or, look at <http://www.hhs.gov/ocr/hipaa> on the web.

If you are in a Medicare managed care plan or a Medicare Private Fee-for-Service plan, you also have the right to timely access to your medical records.

Words in red are defined on pages 25-27.

Section 3: Your Rights and Protections in the Original Medicare Plan

In addition to the rights listed in Section 2, if you are in the Original Medicare Plan or have a Medigap policy, you have the following rights and protections:

Culturally Competent Services

Hospitals, home health agencies, skilled nursing facilities, and hospice facilities must give you health care services in a language you can understand and in a culturally sensitive way. For more information about getting health care services in languages other than English, call the Office for Civil Rights in your state. You can get this telephone number at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227).

Access to Doctors, Specialists (including Women's Health Specialists), and Hospitals

You have the right to go to any doctor, specialist, or hospital that accepts Medicare.

Appeal Billing, Payment, and Service Issues

You have the right to a fair, efficient, and timely process to resolve issues about payment for a Medicare-covered service or product. This process includes a system of internal review and an independent external review.

You can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service that you received. Your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from the company that handles bills for Medicare. The notice will tell you why your bill was not paid, how long you have to file an appeal, and what appeal steps you can take. If you decide to file an appeal, ask your doctor or provider for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

Words in red are defined on pages 25-27.

To Know If A Service You Are Getting Will Not Be Paid For

You have the right to know if Medicare probably (or certainly) will not pay for items or services that are usually covered. Your doctor, provider, or supplier of health care items or

Section 3: Your Rights and Protections in the Original Medicare Plan

To Know If A Service You Are Getting Will Not Be Paid For (continued)

services should give you a written notice before they give you any item or service that they think Medicare will probably not pay for. This written notice is called an Advance Beneficiary Notice (ABN). The ABN tells you what items and services Medicare will not pay for and why Medicare won't pay for it. The ABN gives you the chance to make an informed decision about whether you are willing to get the items or services when you will probably have to pay for the items or services out of your own pocket or through other insurance you might have.

What to do if you get an ABN

If your doctor, provider, or supplier gives you an ABN, you will have to decide if you want the items or services. You will be asked to choose between Option 1 or Option 2 by marking a box and signing the ABN. If you choose Option 1, this means you want the items or services and agree to pay for them out of your own pocket or through other health insurance you may have, if Medicare does not pay. If you choose Option 2, this means you do not want the items or services. You can only get an official Medicare decision if you choose Option 1.

If you aren't sure if Medicare was billed for the items or services that you got, write or call your health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from your doctor, hospital, or any other health supplier. You should get your copy of the itemized statement within 30 days. Also, you can check your Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to see if the service was billed to Medicare.

Services that Medicare doesn't cover

Doctors and suppliers of health care services don't have to give you an ABN for services that Medicare doesn't cover, such as:

- Routine physical exams.
- Dental services.
- Hearing aids.
- Orthopedic shoes.
- Routine eye exams.

Words in red are defined on pages 25-27.

Section 3: Your Rights and Protections in the Original Medicare Plan

When You Are in the Hospital

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you are not given a copy, ask for it.

The *Important Message From Medicare* notice tells you:

- You have the right to get all of the hospital care you need, and any follow-up care that is covered by the Original Medicare Plan after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.
- What your appeal rights are.
- What you may have to pay.

When the hospital staff thinks you no longer need inpatient hospital care, they will notify you of your discharge and appeal rights. If you are not given a notice, ask for it.

This notice explains:

- Why you are being discharged.
- How to get an immediate review.
- When to ask for an immediate review.
- What you may have to pay.

When you get this notice, you can ask for an immediate review by the Peer Review Organization (PRO). To get an immediate review, you can call or write the PRO. **You may be able to stay in the hospital at no charge while the Peer Review Organization reviews your case. The hospital cannot force you to leave before the PRO makes a decision.**

Before you are discharged from the hospital, the hospital must notify you of your discharge and appeal rights. If the hospital does not notify you of your discharge and appeal rights and you decide to stay in the hospital after your discharge date, you can't be charged for the costs of your care.

If you have questions about your rights as a hospital patient, call the PRO in your state. Their telephone number is on the copy of the *Important Message From Medicare* notice that you get at the hospital. PRO telephone numbers are also in this booklet on page 22.

Words in red are defined on pages 25-27.

Section 3: Your Rights and Protections in the Original Medicare Plan

When You Are in a Skilled Nursing Facility

A skilled nursing facility (SNF) is a Medicare-certified facility that has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. You must meet certain conditions, such as a 3-day hospital stay, for skilled nursing facility care coverage before you are admitted. Some nursing homes give this type of skilled care.

If you are in a SNF, you are protected when your coverage ends. The SNF staff gives you a *Notice of Non-Coverage* when they think you no longer qualify for Medicare coverage. But if you think that you still need skilled nursing facility care, you have the right to have Medicare review the SNF's opinion to decide if you still qualify for Medicare coverage.

To have Medicare decide if you still qualify for SNF coverage:

1. The SNF must send a special kind of claim to Medicare. This special claim is sometimes called a Demand Bill. Check off the box on the *Notice of Non-Coverage* to show that you want a Demand Bill sent to Medicare.
2. Give the Notice to the SNF.
3. The SNF sends the Demand Bill to Medicare.
4. Medicare decides if you still qualify for Medicare-covered SNF care.
5. The SNF will let you know what the decision is.

The SNF must submit the Demand Bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare makes its decision. You must continue to pay any costs that you would normally have to pay while the Demand Bill is being processed. This includes the daily coinsurance and the costs for services and supplies not covered by Medicare.

Words in red are defined on pages 25-27.

If Medicare decides your care is no longer covered, you are responsible for the cost of the care you got while you were waiting for the decision.

Section 3: Your Rights and Protections in the Original Medicare Plan

When You Are in a Skilled Nursing Facility (continued)

You can file an appeal if you do not agree with this decision. To find out how to appeal in the Original Medicare Plan, read the back of the Explanation of Medicare Benefits (EOMB), Medicare Summary Notice (MSN), or Notice of Utilization you get from the company that handles bills for Medicare.

When Your Home Health Care Ends

If you are getting home health care services, you are protected when your home health care is reduced or ends. Home health care agencies must give you a written Home Health Advance Beneficiary Notice (HHABN) that explains why and when they think Medicare will stop paying for all or part of your home health care. Also, home health care agencies must give you a written notice before you get home health care if they think Medicare will not pay for some or all of the home health care services your doctor ordered.

What to do if you get an HHABN

If your home health agency gives you an HHABN, you will have to decide if you want the services or not. You will be asked to choose between Option A, Option B, or Option C. If you choose Option A, this means you want the services and agree to pay for them out of your own pocket or through other health insurance you may have, if Medicare does not pay. If you choose Option B, this means you do not want the services. If you choose Option C, this means you want the services, but do not want the home health agency to send a claim to Medicare. The home health agency may send the claim to you or the other health insurance you may have. You can only get an official Medicare decision if you choose Option A.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this decision.
- Pay the home health agency for those services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay. If Medicare does not decide in your favor, you can appeal (see page 7).

Words in red are defined on pages 25-27.

Section 3: Your Rights and Protections in the Original Medicare Plan

When Your Home Health Care Ends (continued)

If Medicare decides to pay, you will get back any of your payments that you are due. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care in the Original Medicare Plan, call the Regional Home Health Intermediary (RHHI) in your state. These telephone numbers are listed on page 23.

To Buy a Medigap Policy in Certain Situations

If you lose certain types of health care coverage, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called “Medigap Protections.” They are also called “guaranteed issue rights” because the law says that insurance companies must issue you a policy.

The situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy are:

- Your Medicare managed care plan, Medicare Private Fee-for-Service plan, Program of All-Inclusive Care for the Elderly (PACE) provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area.
- Your Medicare managed care plan, Medicare Private Fee-for-Service plan, Medicare SELECT policy, or PACE program ends your coverage because you move out of the plan’s service area.
- You are in an employer group health plan that pays some of the costs not paid for by Medicare, and the plan ends your coverage.
- Your Medigap policy terminates because the insurance company goes bankrupt or insolvent, and state law does not provide for you to get conversion coverage.

Words in red are defined on pages 25-27.

Section 3: Your Rights and Protections in the Original Medicare Plan

To Buy a Medigap Policy in Certain Situations (continued)

- You dropped your Medigap policy to join a Medicare managed care plan, Medicare Private Fee-for-Service plan, or PACE program and then leave the plan within one year after joining, or you buy a Medicare SELECT policy for the first time and drop the policy within one year after buying.
- You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Medicare Private Fee-for-Service plan) or a PACE program when you first became eligible for Medicare at age 65 and you leave the plan within one year of joining.
- A change in your circumstances, such as moving out of the plan's service area, gives you the right to leave (disenroll from) your plan.

The Medigap protections listed above and on page 14 are from federal law. Many states provide more Medigap protections than federal law. This information is at www.medicare.gov on the web. Select "Medigap Compare." You can also call your State Health Insurance Assistance Program (SHIP) (see page 24) or State Insurance Department for more information. You

can get the telephone number for the State Insurance Department in your state at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227).

For more detailed Medigap information, look at "Medigap Compare" on the web at www.medicare.gov. Or, select "Publications" and choose the booklet the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*. You can also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this booklet.

If you think any of your Medigap rights have been violated, call the State Health Insurance Assistance Program (SHIP) in your state. These telephone numbers are listed on page 24.

Words in red are defined on pages 25-27.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

In addition to the rights listed in Section 2, if you are in a Medicare managed care plan, you have the following rights and protections:

Culturally Competent Services

You have the right to get health care services in a language you can understand and in a culturally sensitive way.

Choice of Health Care Providers

You have the right to choose health care providers within the plan so you can get the health care you need.

Access to Health Care Providers

If you have a complex or serious medical condition, you have the right to get a treatment plan from your doctor that lets you directly see a specialist within the plan as many times as you and your doctor think you need.

Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.

Know How Your Doctors Are Paid

You have the right to find out how your health plan pays its doctors. When you ask your health plan how it pays its doctors, the health plan must tell you. Medicare does not allow a health plan to pay doctors in a way that would not let you get the care you need.

Appeal Billing, Payment, and Service Issues

Words in red are defined on pages 25-27.

You have the right to a fair, efficient, and timely process to resolve differences with your health plan. This process includes a system of internal review and an independent external review.

You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service you think should be covered or provided. This includes home health care and care you get in a skilled nursing facility. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

Appeal Billing, Payment, and Service Issues (continued)

The plan must tell you in writing why they will not pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan does not decide in your favor, your appeal is automatically sent to an independent organization that works for Medicare, not for the plan. This independent organization will review your appeal. Your plan must give you a copy of your case file if you ask for it.

See your plan's membership materials or call your plan for details about your appeal rights.

File A Grievance About Other Concerns or Problems

You have a right to file a grievance if you have concerns or problems with your Medicare managed care plan that are not about payment or service requests. For example, if you believe your plan's hours of operation should be different, or there are not enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

When You Are in the Hospital

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you are not given a copy, ask for it.

The *Important Message From Medicare* notice tells you:

- You have the right to get all of the hospital care you need, and any follow-up care that is covered by your Medicare managed care plan after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.
- What your appeal rights are.
- What you may have to pay.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

When You Are in the Hospital (continued)

When the hospital staff thinks you no longer need inpatient hospital care, they will notify you of your discharge and appeal rights. If you are not given a notice, ask for it. This notice explains:

- Why you are being discharged.
- How to get an immediate review.
- When to ask for an immediate review.
- What you may have to pay.

When you get this notice, if you think the hospital is making you leave too soon, you can ask for an immediate review by the Peer Review Organization (PRO). To get an immediate review, you can call or write the PRO. **You may be able to stay in the hospital at no charge while the Peer Review Organization reviews your case. The hospital cannot force you to leave before the PRO makes a decision.**

Before you are discharged from the hospital, the hospital must notify you of your discharge and appeal rights. If the hospital does not notify you of your discharge and appeal rights and you decide to stay in the hospital after your discharge date, you can't be charged for the costs of your care.

If you have questions about your rights as a hospital patient, call your Medicare managed care plan or the PRO in your state. Their telephone numbers are on the notice of discharge and appeal rights the hospital gives you. PRO telephone numbers are also on the copy of the *Important Message From Medicare* notice and in this booklet on page 22.

When You Are in a Skilled Nursing Facility

If you are in a skilled nursing facility, the plan must tell you in writing when you do not need skilled care any longer. If you want to appeal this decision, the plan's *Notice of Non-Coverage* will tell you the steps you need to take. The plan may have to continue to pay the costs of your care if you do not get proper notice. Call your plan for more information about skilled nursing facility coverage.

When Your Home Health Care Ends

If you have questions about home health care rights and protections, call your plan.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan

In addition to the rights listed in Section 2, if you are in a Medicare Private Fee-for-Service plan, you have the following rights and protections:

Culturally Competent Services

You have the right to get health care services in a language you can understand and in a culturally sensitive way.

Appeal Billing, Payment, and Service Issues

You have the right to a fair, efficient, and timely process to resolve differences with your health plan. This process includes a system of internal review and an independent external review.

You have the right to file an appeal if your plan will not pay for, does not allow, or stops a service you think should be covered or provided. This includes home health care and care you get in a skilled nursing facility. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

The plan must tell you in writing why they will not pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan does not decide in your favor, your appeal is automatically sent to an independent organization that works for Medicare, not for the plan. This independent organization will review your appeal. Your plan must give you a copy of your case file if you ask for it.

See your plan's membership materials or call your plan for details about your appeal rights.

Words in red are defined on pages 25-27.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan

File A Grievance About Other Concerns or Problems

You have a right to file a grievance if you have concerns or problems with your Medicare Private Fee-for-Service plan that are not about payment or service requests. For example, if you believe your plan's hours of operation should be different, or there are not enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

Call your Medicare Private Fee-for-Service plan:

- Before you get a service or supply to find out if it will be covered. Your plan must tell you if you ask.
- To find out what your protections are when you are in the hospital.
- To get information about skilled nursing facility coverage. If you are in a skilled nursing facility, the plan must tell you in writing when you do not need skilled care any longer. If you want to appeal this decision, the plan's *Notice of Non-Coverage* will tell you the steps you need to take. The plan may have to continue to pay the costs of your care if you do not get proper notice.
- If you have questions about home health care rights and protections.

Words in red are
defined on pages
25-27.

Section 6: For More Information

Call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about Medicare. A customer service representative can answer your questions between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday. The best times to call are Wednesday, Thursday, or Friday afternoons.

You can also use this telephone number 24 hours a day, 7 days a week to:

- Order Medicare publications,
- Get detailed information about the Medicare health plans in your area, and
- Listen to recorded questions and answers on topics such as Medicare health plan choices and health plan quality information.

Booklets On Other Medicare Topics

If you want more information on Medicare topics of interest, look at www.medicare.gov on the web. Select “Publications.” Or, call 1-800-MEDICARE (1-800-633-4227). Many free booklets are available in English, Spanish, audiotape (English and Spanish), Braille, and large print (English and Spanish). Some booklets are also available in Chinese.

Some of the booklets below have more information on topics covered in this booklet:

- *Medicare and Home Health Care.*
- *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy.*
- *Medicare Coverage of Skilled Nursing Facility Care.*
- *Your Guide to Private-Fee-for-Service plans.*

Section 6: For More Information

Peer Review Organization (PRO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

| | | | |
|----------------------|----------------|-----------------------------------|----------------------|
| Alabama | (800) 760-3540 | Nebraska..... | (800) 247-3004 |
| Alaska..... | (800) 445-6941 | Nevada | (800) 748-6773 |
| American Samoa | (800) 524-6550 | New Hampshire | (603) 749-1641 |
| Arizona..... | (800) 359-9909 | New Jersey..... | (732) 238-5570 |
| Arkansas..... | (800) 272-5528 | New Mexico..... | (800) 279-6824 |
| California | (800) 841-1602 | New York | (800) 331-7767 |
| Colorado..... | (800) 727-7086 | North Carolina | (800) 722-0468 |
| Connecticut | (800) 553-7590 | North Dakota | (701) 852-4231 |
| Delaware | (302) 475-8100 | Northern Mariana Islands | (800) 524-6550 |
| Florida | (800) 844-0795 | Ohio | (800) 589-7337 |
| Georgia..... | (800) 979-7217 | Oklahoma..... | (405) 840-2891 |
| Guam | (800) 524-6550 | Oregon | (800) 344-4354 |
| Hawaii | (800) 524-6550 | Pennsylvania | (800) 322-1914 |
| Idaho..... | (800) 445-6941 | Puerto Rico..... | (787) 641-1240 |
| Illinois | (800) 647-8089 | Rhode Island | (800) 662-5028 |
| Indiana | (800) 288-1499 | South Carolina | (803) 731-8225 |
| Iowa | (800) 752-7014 | South Dakota | (800) 658-2285 |
| Kansas | (800) 432-0407 | Tennessee | (800) 489-4633 |
| Kentucky | (800) 288-1499 | Texas | (800) 725-8315 |
| Louisiana | (225) 926-6353 | Utah | (800) 274-2290 |
| Maine | (603) 749-1641 | Vermont | (603) 749-1641 |
| Maryland | (800) 492-5811 | Virgin Islands | (340) 712-2400 |
| Massachusetts..... | (781) 890-0011 | Virginia..... | (804) 289-5304 |
| Michigan | (800) 365-5899 | Washington..... | (800) 445-6941 |
| Minnesota..... | (800) 444-3423 | Washington D.C. | (800) 645-0011 |
| Mississippi | (800) 844-0600 | West Virginia | (800) 642-8686 x2266 |
| Missouri | (800) 347-1016 | Wisconsin..... | (800) 362-2320 |
| Montana | (800) 497-8232 | Wyoming | (800) 497-8232 |

Section 6: For More Information

Regional Home Health Intermediary (RHHI): Call about questions on home health care, hospice care, and fraud and abuse.

Alabama(800) 583-2236
Alaska(877) 602-7904
American Samoa(877) 602-7904
Arizona(877) 602-7904
Arkansas(800) 583-2236
California(877) 602-7904
Colorado.....(877) 910-8139
Connecticut(888) 896-4997
Delaware(877) 910-8139
Florida(800) 583-2236
Georgia.....(800) 583-2236
Guam(877) 602-7904
Hawaii(866) 264-4990
Idaho.....(877) 602-7904
Illinois(800) 583-2236
Indiana(800) 583-2236
Iowa(877) 910-8139
Kansas(877) 910-8139
Kentucky(800) 583-2236
Louisiana(800) 583-2236
Maine(888) 896-4997
Maryland(877) 910-8139
Massachusetts.....(888) 896-4997
Michigan(800) 531-9695
Minnesota.....(800) 531-9695
Mississippi(800) 583-2236
Missouri(877) 910-8139
Montana(877) 910-8139
Nebraska(877) 910-8139

Nevada(877) 602-7904
New Hampshire(888) 896-4997
New Jersey.....(800) 531-9695
New Mexico.....(800) 583-2236
New York(800) 531-9695
North Carolina(800) 583-2236
North Dakota(877) 910-8139
Northern Mariana
Islands(877) 602-7904
Ohio(800) 583-2236
Oklahoma.....(800) 583-2236
Oregon(877) 602-7904
Pennsylvania(877) 910-8139
Puerto Rico(800) 531-9695
Rhode Island(888) 896-4997
South Carolina(800) 583-2236
South Dakota(877) 910-8139
Tennessee(800) 583-2236
Texas(800) 583-2236
Utah(877) 910-8139
Vermont(888) 896-4997
Virgin Islands(800) 531-9695
Virginia(877) 910-8139
Washington.....(877) 602-7904
Washington D.C.(877) 910-8139
West Virginia(877) 910-8139
Wisconsin.....(800) 531-9695
Wyoming(877) 910-8139

Section 6: For More Information

State Health Insurance Assistance Program (SHIP): Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

| | | | |
|----------------------|----------------|-----------------------------------|----------------------|
| Alabama | (800) 243-5463 | Nebraska..... | (800) 234-7119 |
| Alaska..... | (907) 269-3680 | Nevada | (800) 307-4444 |
| American Samoa | (888) 875-9229 | New Hampshire | (603) 225-9000 |
| Arizona..... | (800) 432-4040 | New Jersey | (609) 588-3139 |
| Arkansas..... | (800) 224-6330 | New Mexico..... | (505) 827-7640 |
| California | (800) 434-0222 | New York | (800) 333-4114 |
| Colorado..... | (888) 696-7213 | North Carolina | (919) 733-0111 |
| Connecticut | (860) 424-5245 | North Dakota | (800) 247-0560 |
| Delaware | (302) 739-6266 | Northern Mariana Islands | (888) 875-9229 |
| Florida | (800) 963-5337 | Ohio | (800) 686-1578 |
| Georgia..... | (800) 669-8387 | Oklahoma..... | (405) 521-6628 |
| Guam | (888) 875-9229 | Oregon | (503) 947-7263 |
| Hawaii | (888) 875-9229 | Pennsylvania | (800) 783-7067 |
| Idaho..... | (208) 334-4350 | Puerto Rico..... | (787) 721-8590 |
| Illinois | (217) 785-9021 | Rhode Island | (401) 222-2880 |
| Indiana | (317) 233-3475 | South Carolina | (803) 898-2850 |
| Iowa | (800) 351-4664 | South Dakota | (605) 773-3656 |
| Kansas | (316) 337-7386 | Tennessee | (800) 525-2816 |
| Kentucky | (502) 564-2347 | Texas | (800) 252-9240 |
| Louisiana | (225) 342-5301 | Utah | (801) 538-3910 |
| Maine | (207) 623-1797 | Vermont | (802) 748-5182 |
| Maryland | (410) 767-1100 | Virgin Islands | (340) 778-6311 x2338 |
| Massachusetts..... | (617) 727-7750 | Virginia..... | (800) 552-3402 |
| Michigan | (800) 803-7174 | Washington..... | (800) 397-4422 |
| Minnesota..... | (800) 333-2433 | Washington D.C. | (202) 739-0668 |
| Mississippi | (800) 948-3090 | West Virginia | (877) 987-4463 |
| Missouri | (800) 390-3330 | Wisconsin..... | (800) 242-1060 |
| Montana | (406) 444-7781 | Wyoming | (800) 856-4398 |

Section 7: Words To Know

Advance Beneficiary Notice (ABN) - A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases:

1. Your doctor or supplier gives you a service that he or she believes that Medicare does not consider medically necessary; and
2. Your doctor or supplier gives you a service that he or she believes that Medicare will not pay for.

If you do not get an ABN to sign before you get the service from your doctor, and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor for it. ABNs are only used in the Original Medicare Plan. It does not apply if you are in a Medicare managed care plan.

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay or doesn't pay enough for a service you got or would like to get. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is a special process you must use to make your complaint.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

End-Stage Renal Disease (ESRD) - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Explanation of Medicare Benefits

(EOMB) - A notice that is sent to you after the doctor files a claim for Part B services in the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly. (See Medicare Summary Notice.)

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Guaranteed Issue Rights - Rights you have in certain situations when insurance companies are required by law to issue you a Medigap policy.

Section 7: Words To Know

Home Health Care - Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Hospice - Hospice is a special way of caring for people who are terminally ill, and for their family. This includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Medicare - The Federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Managed Care Plan - These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare SELECT - A type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor files a claim for Part A and Part B services under the Original Medicare Plan. It explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services, or a Notice of Utilization.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period (Medigap) - A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your health history during this time.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private-Fee-for-Service plans, and ambulatory surgical centers.

Section 7: Words To Know

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any Medicare approved doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Program of All-Inclusive Care for the Elderly (PACE) - PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Provider - A doctor, hospital, health care professional, or health care facility.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.

Regional Home Health Intermediary (RHHI) - A private company that contracts with Medicare to pay home health bills and checks on the quality of home health care.

Skilled Nursing Facility (SNF) - A facility that provides skilled nursing or rehabilitative services to help you recover after a hospital stay.

Skilled Nursing Facility Care* - A level of care that must be given or supervised by licensed nurses. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

*This definition in whole or in part was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology 2000.

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HEALTH CARE FINANCING ADMINISTRATION
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Official Business
Penalty for Private Use, \$300

Publication No. HCFA - 10112
May 2001

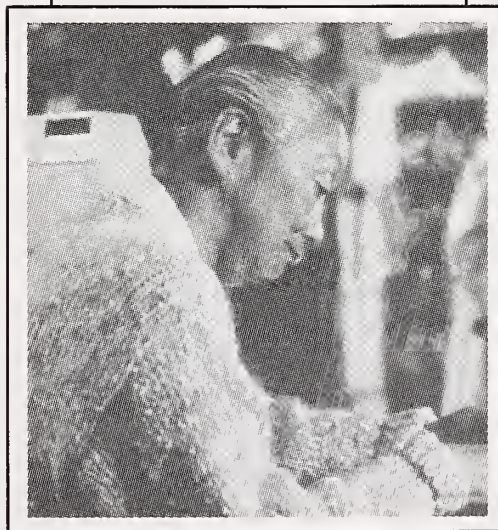
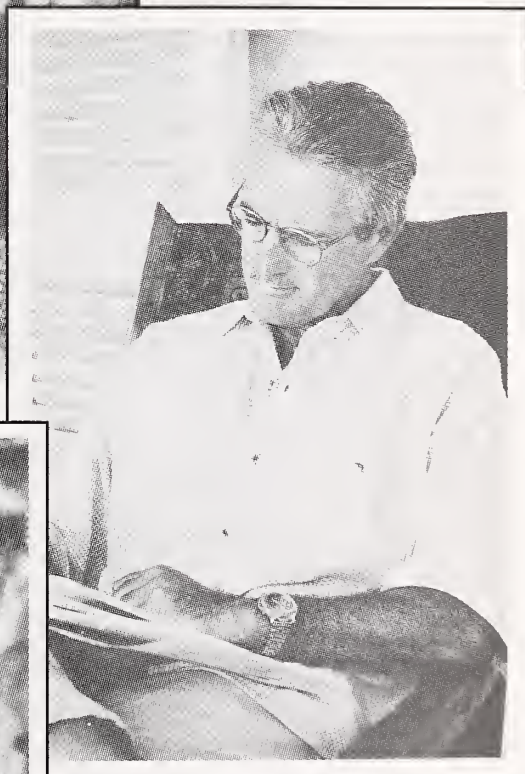
- Necesita usted una copia en Español? Por favor llame gratis al 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 para personas con impedimentos auditivos o del lenguaje oral).
- Do you need a copy in Chinese? Look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of this booklet.



PUBLICATIONS CATALOG

Free Booklets About Medicare and Related Topics

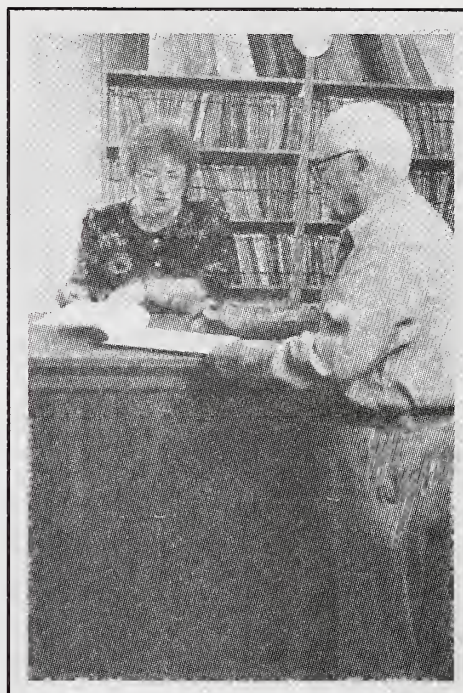
- ABOUT BASIC MEDICARE INFORMATION
- ABOUT SERVICES MEDICARE COVERS
- ABOUT HEALTH CARE CHOICES
- ABOUT MEDICARE HEALTH PLAN CHOICES
- ABOUT COSTS AND PAYMENTS
- ABOUT YOUR RIGHTS AND PROTECTIONS



Visit www.medicare.gov

Free Booklets About Medicare and Related Topics

Medicare is a health insurance program for people age 65 and older, some people with disabilities under age 65, people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant. This catalog describes the many free booklets that are available to help people with Medicare understand their benefits and to get answers to their questions about Medicare.



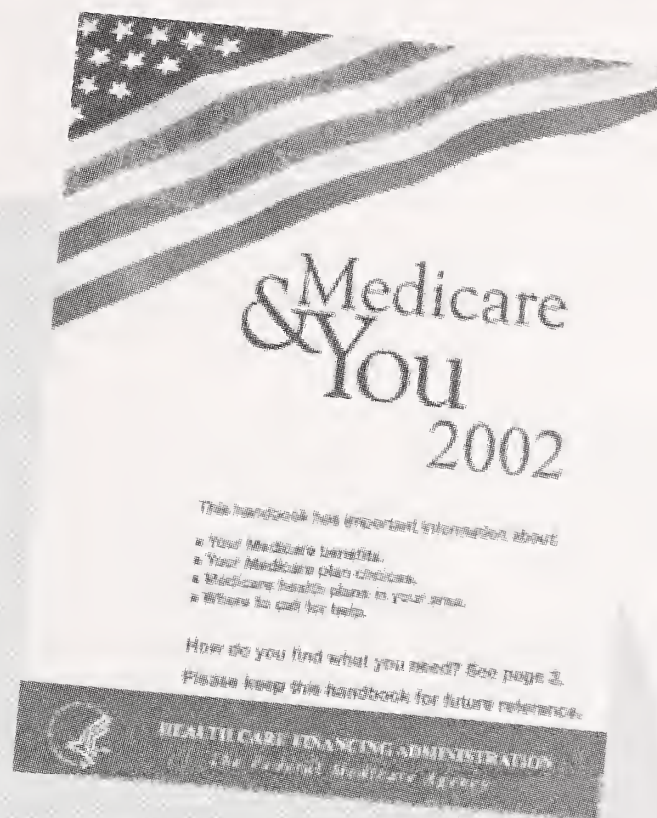
How do I get these booklets?

You can:

1. Look at www.medicare.gov on the Web and select "Publications." You can read, print, or order these booklets.
2. Put your name on the Web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Subscribe to Our Mailing List." Then, select "Publications," type your e-mail address in the box at the bottom, and select "Subscribe."
3. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the booklet you want. To order Medicare booklets, press option "4."

Call 1-800-MEDICARE (1-800-633-4227)

About Basic Medicare Information



Medicare & You 2002

This basic reference guide helps people with Medicare learn about the health care choices they have. It gives basic facts about the Medicare program, Medicare health plan choices, and other insurance and ways to pay health care costs. The handbook includes a list of phone numbers to call if you need help.

Available October 2001.

Available in:

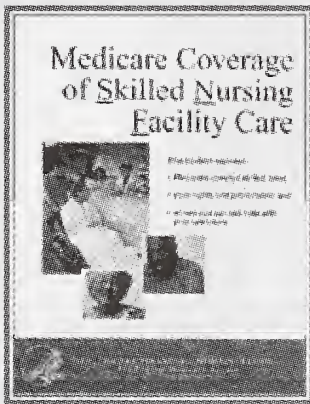
English (HCFA Pub. No. 10050),
Spanish (HCFA Pub. No. 10050-S),
English Audiotape (HCFA Pub. No. 10050-RE),
Spanish Audiotape (HCFA Pub. No. 10050-RS),
Braille (HCFA Pub. No. 10050-B),
English Large Print (HCFA Pub. No. 10050-LE), and
Spanish Large Print (HCFA Pub. No. 10050-LS).



About Services Medicare Covers

Medicare Coverage of Skilled Nursing Facility (SNF) Care

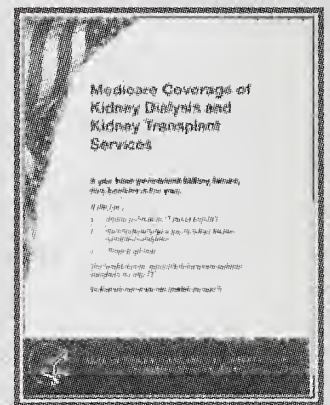
This informative booklet includes details on Medicare skilled nursing facilities (SNF) coverage, how to find and compare SNF's, your SNF rights and protections, and a list of important telephone numbers. Be sure to use the useful tips and checklists that can help you evaluate the SNFs that you visit.



Available in English (HCFA Pub. No. 10153),
Spanish (HCFA Pub. No. 10153-S),
English Audiotape (HCFA Pub. No. 10153-RE),
Spanish Audiotape (HCFA Pub. No. 10153-RS),
Braille (HCFA Pub. No. 10153-B),
English Large Print (HCFA Pub. No. 10153-LE), and
Spanish Large Print (HCFA Pub. No. 10153-LS).

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

If you have permanent kidney failure, this booklet is for you. It discusses how to get Medicare if your kidneys fail, how Medicare helps pay for kidney dialysis and kidney transplants, and where to get help. It was updated in 2000.

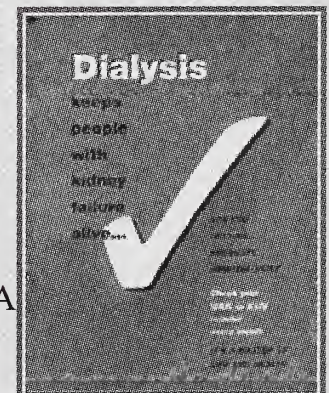


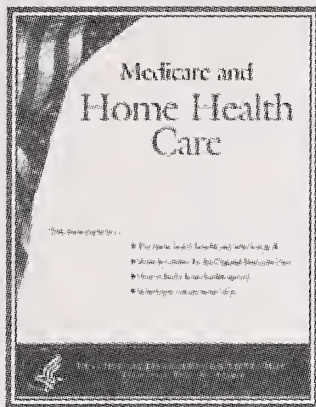
Available in English (HCFA Pub. No. 10128),
Spanish (HCFA Pub. No. 10128-S),
English Audiotape (HCFA Pub. No. 10128-RE),
Spanish Audiotape (HCFA Pub. No. 10128-RS),
Braille (HCFA Pub. No. 10128-B),
English Large Print (HCFA Pub. No. 10128-LE), and
Spanish Large Print (HCFA Pub. No. 10128-LS).

Dialysis

This booklet includes important information for people on hemodialysis. It's a matter of life and health.

Available in English (HCFA Pub. No. 10924), and Spanish (HCFA Pub. No. 10924-S).





Medicare and Home Health Care

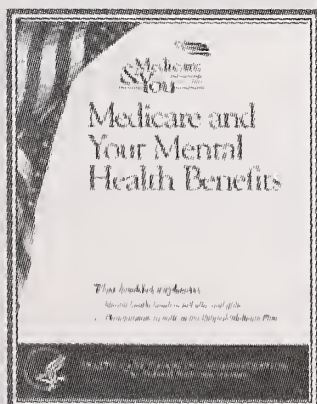
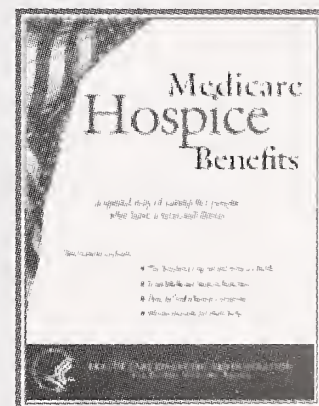
Find out if you are eligible for Medicare home health care benefits. Read this booklet to learn what Medicare covers and what kinds of questions to ask when choosing a home health care agency.

Available in English (HCFA Pub. No. 10969), Spanish (HCFA Pub. No. 10969-S), English Audiotape (HCFA Pub. No. 10969-RE), Spanish Audiotape (HCFA Pub. No. 10969-RS), and Braille (HCFA Pub. No. 10969-B).

Medicare Hospice Benefits

Hospice care is a special type of care for terminally ill patients. This booklet lists tips on how to find a hospice program, explains Medicare coverage, and tells you where to get more information.

Available in English (HCFA Pub. No. 02154), Spanish (HCFA Pub. No. 02154-S), English Audiotape (HCFA Pub. No. 02154-RE), Spanish Audiotape (HCFA Pub. No. 02154-RS), Braille (HCFA Pub. No. 02154-B), English Large Print (HCFA Pub. No. 02154-LE), and Spanish Large Print (HCFA Pub. No. 02154-LS).



Medicare and Your Mental Health Benefits

Your mental health is an important part of your overall well-being. Use this booklet to learn what is covered under Medicare, who is eligible, and where to get help with questions.

Available in English (HCFA Pub. No. 10184), and Spanish (HCFA Pub. No. 10184-S).



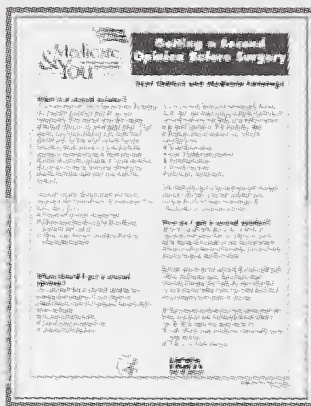
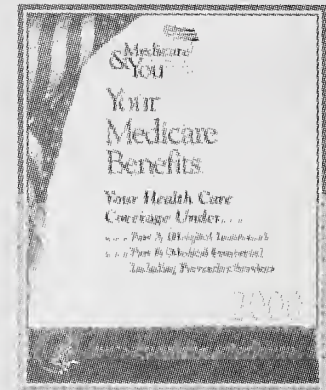
About Services Medicare Covers

(continued)

Your Medicare Benefits

It's important to know what Medicare covers. Learn about both Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) with this booklet.

Available in English (HCFA Pub. No. 10116), and Spanish (HCFA Pub. No. 10116-S) and Chinese (HCFA Pub. No. 10116-C).



Getting A Second Opinion Before Surgery

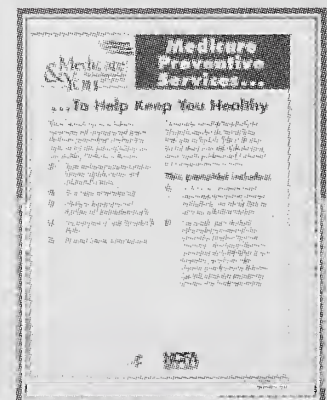
This brochure tells you about Medicare coverage, and includes a step-by-step guide on how to get a second surgical opinion. Use this brochure to be prepared in case surgery is needed.

Available in English (HCFA Pub. No. 02173), and Spanish (HCFA Pub. No. 02173-S).

Medicare Preventive Services

This pamphlet gives information to help keep you healthy! Use it to find out how to lower your risk of cancer, flu, pneumococcal pneumonia, diabetes, and other illnesses. Includes a chart that tells you which tests and shots Medicare covers. It also has handy tear-out reminder cards you can take to the doctor's office.

Available in English (HCFA Pub. No. 10110), and Spanish (HCFA Pub. No. 10110-S) and Chinese (HCFA Pub. No. 10110-C).



NEW!

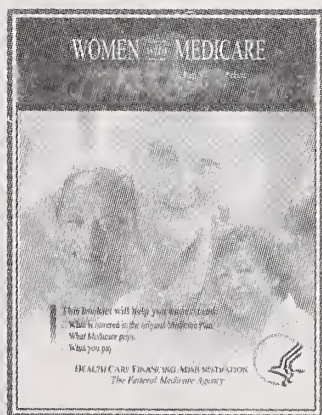
Medicare & Clinical Trials

Learn about how Medicare now covers some care for people with Medicare who join clinical trials for the diagnosis and treatment of illnesses.

Available in English (HCFA Pub. No. 02226), and Spanish (HCFA Pub. No. 02226-S).



NEW!



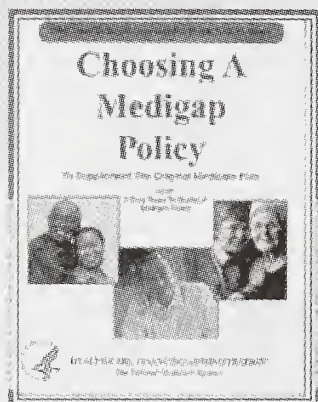
Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam

This booklet provides information on three common preventive services for women with Medicare: the Pap test, pelvic exam, and clinical breast exam. It includes what services Medicare covers, what Medicare pays, and what you will pay.

Available in English (HCFA Pub. No. 02248), and Spanish (HCFA Pub. No. 02248-S).



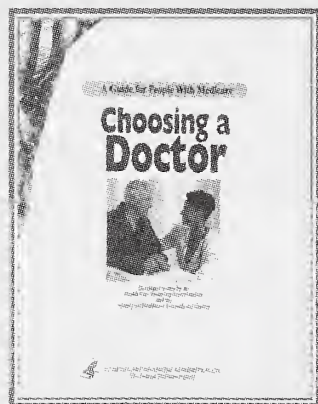
About Health Care Choices



2001 Guide To Health Insurance For People With Medicare: Choosing A Medigap Policy

This detailed guide describes how to choose a Medigap policy to supplement the Original Medicare Plan. It provides six easy steps to buying a Medigap policy, important tips to help you buy the Medigap policy that's right for you, and information on your Medigap protections if you lose health coverage.

Available in English (HCFA Pub. No. 02110),
Spanish (HCFA Pub. No. 02110-S),
English Audiotape (HCFA Pub. No. 02110-RE),
Spanish Audiotape (HCFA Pub. No. 02110-RS),
Braille (HCFA Pub. No. 02110-B),
English Large Print (HCFA Pub. No. 02110-LE), and
Spanish Large Print (HCFA Pub. No. 02110-LS).



Choosing a Doctor: A Guide for People with Medicare

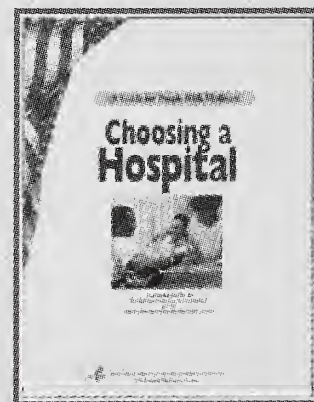
This guide contains useful information to help find the right doctor for you. It includes worksheets to help decide what you want in a doctor, questions to ask, and excellent resources for more information.

Available in English (HCFA Pub. No. 10180),
Spanish (HCFA Pub. No. 10180-S), and
Braille (HCFA Pub. No. 10180-B).

Choosing a Hospital: A Guide for People with Medicare

This guide provides useful tips on choosing the facility that best meets your or a family members needs for hospital care. It includes excellent referrals for more information on quality care.

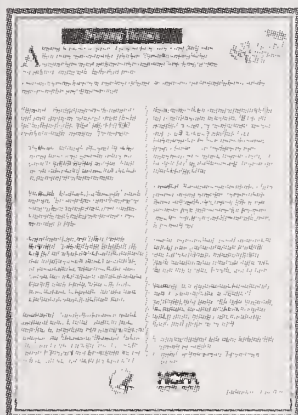
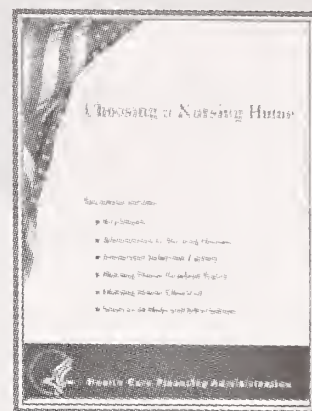
Available in English (HCFA Pub. No. 10181),
Spanish (HCFA Pub. No. 10181-S), and
Braille (HCFA Pub. No. 10181-B).



Your Guide to Choosing a Nursing Home

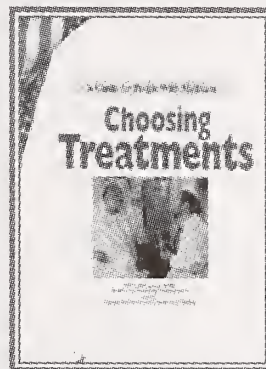
This guide discusses what to look for in a nursing home if you or a family member need one. It includes an evaluation checklist and a list of helpful resources for selecting a nursing home.

Available in English (HCFA Pub. No. 02174),
Spanish (HCFA Pub. No. 02174-S),
English Audiotape (HCFA Pub. No. 02174-RE),
Spanish Audiotape (HCFA Pub. No. 02174-RS),
and
Braille (HCFA Pub. No. 02174-B).



Nursing Homes

This fact sheet includes basic information on how to choose a nursing home and where to get more information, including a search tool called "Nursing Home Compare" on the Web at www.medicare.gov.



Choosing Treatments: A Guide for People with Medicare

This guide provides advice and worksheets to help you work with your

doctor to help you choose the best treatment for any health problem. Includes excellent referrals for more information.

Available in English (HCFA Pub. No. 10182),
Spanish (HCFA Pub. No. 10182-S), and
Braille (HCFA Pub. No. 10182-B).

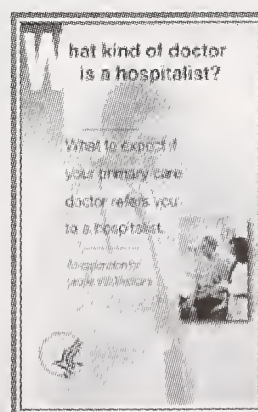
Available in English (HCFA Pub. No. 10121).

Coming Soon!

Choosing Long-term Care: A Guide for People with Medicare

This guide will help you understand long-term care options if you or family members need them. It will include information on who provides long-term care services, how to pay for long-term care, and more.

Will be available in English (HCFA Pub. No. 02223),
Spanish (HCFA Pub. No. 02223-S), and
Braille.



What Kind of Doctor is a Hospitalist?

This booklet explains what to expect if your primary care doctor refers you to a hospitalist for care. Learn the differences between a

primary care doctor and a hospitalist. It includes a chart that compares a primary care doctor and a hospitalist.

Available in English (HCFA Pub. No. 02244),
and Spanish (HCFA Pub. No. 02244-S).

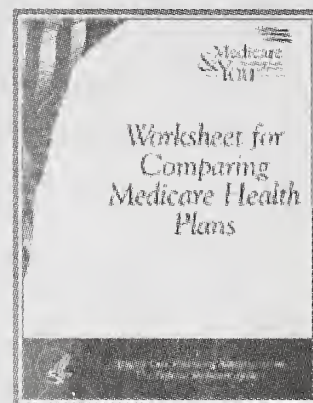


About Medicare Health Plan Choices

Worksheet for Comparing Medicare Health Plans

This worksheet explains your health care options. Use the worksheets to compare health plans and determine which health care plan is right for you!

Available in English (HCFA Pub. No. 10113), and Chinese (HCFA Pub. No. 10113-C).



Choosing a Medicare Health Plan: A Guide for People with Medicare

Coming Soon!

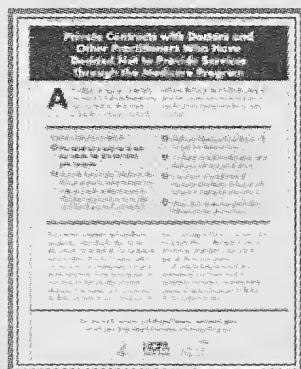
This guide has many tips and questions to help you make the Medicare health plan choice that is right for you. It includes step-by-step instructions that can help you find a Medicare health plan that will meet your needs and give you good quality care.

Available in English (HCFA Pub. No. 02219), Spanish (HCFA Pub. No. 02219-S), and Braille (HCFA Pub. No. 02219-B).

Private Contracts with Doctors and Other Practitioners Who Have Decided Not to Provide Services Through the Medicare Program

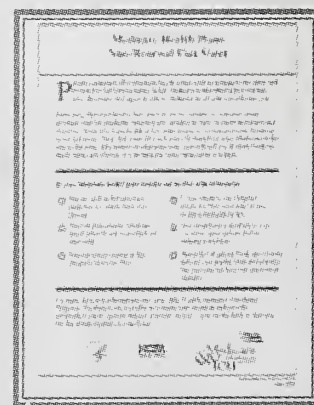
This fact sheet briefly explains about private contracts.

Available in English (HCFA Pub. No. 10109).

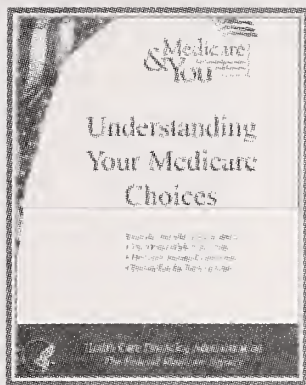


Medicare Health Plans Nonrenewal Fact Sheet

This fact sheet provides useful information if your Medicare health plan leaves the Medicare program. It includes important telephone numbers to call for help.



Available in English (HCFA Pub. No. 10173).



Understanding Your Medicare Choices

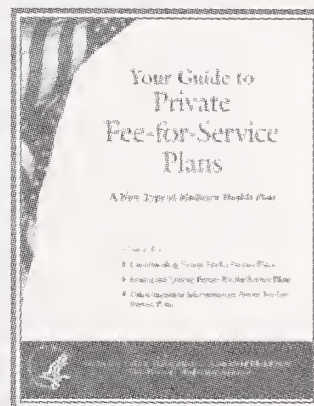
This brochure describes ways you may be able to get your health care and how Medicare works.

Available in English (HCFA Pub. No. 10120), and Spanish (HCFA Pub. No. 10120-S).

Your Guide to Private Fee-for-Service Plans

Learn about one of the Medicare health plan choices available in some areas of the country. This booklet includes detailed information on this plan, with examples and a chart explaining differences among Private Fee-for-Service plans, the Original Medicare Plan, and Medicare managed care plans.

Available in English (HCFA Pub. No. 10144), and Spanish (HCFA Pub. No. 10144-S).



NEW!

New Rules for Switching Medicare Health Plans

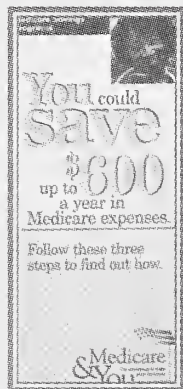
Are you in a Medicare managed care plan now or are you thinking about joining one? The rules for switching Medicare health plans are changing starting January 1, 2002. This booklet explains the new rules that may affect you.

Available in English (HCFA Pub. No. 02241), and Spanish (HCFA Pub. No. 02241-S).





About Costs and Payments



Medicare Savings Programs

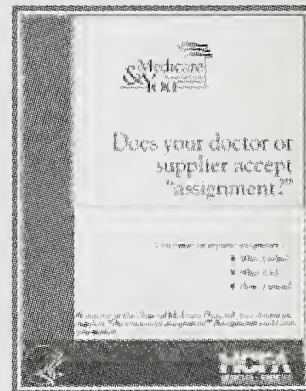
This booklet describes special programs that can help people with low incomes and limited resources save money on their health care costs. Follow these three steps to find out about programs that can put money back in your pocket.

Available in English (HCFA Pub. No. 10126).

Does your doctor or supplier accept “assignment”?

This booklet explains what it means when a doctor or supplier accepts assignment in the Original Medicare Plan. Learn how assignment can save you money if you are in the Original Medicare Plan.

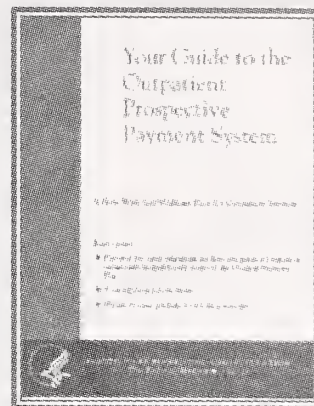
Available in English (HCFA Pub. No. 10134),
Spanish (HCFA Pub. No. 10134-S),
English Audiotape (HCFA Pub. No. 10134-RE),
Spanish Audiotape (HCFA Pub. No. 10134-RS), and
Braille (HCFA Pub. No. 10134-B).



Your Guide to the Outpatient Prospective Payment System

Learn about how the Original Medicare Plan pays for outpatient services since July 2000, and your rights and protections. Includes a list of important telephone numbers and examples.

Available in English (HCFA Pub. No. 02118), and Spanish (HCFA Pub. No. 02118-S).

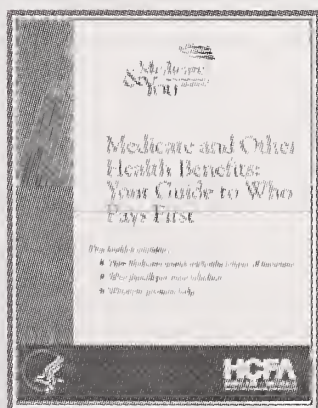


Coming Soon!

Health Care Coverage Directory for People with Medicare

This booklet provides detailed information on the different ways you can get help with your health care costs. These programs may be able to help save you money.

Available in English (HCFA Pub. No. 02231), and Spanish (HCFA Pub. No. 02231-S).



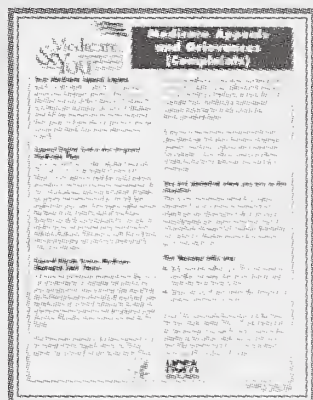
Medicare and Other Health Benefits: Your Guide to Who Pays First

Use this guide to help you understand whether Medicare or your other insurance pays first when you get health care services.

Available in English (HCFA Pub. No. 02179), and Spanish (HCFA Pub. No. 02179-S).



About Your Rights and Protections



Medicare Appeals and Grievances (Complaints)

Learn how to file an appeal or grievance if you have a complaint in the Original Medicare Plan and in other Medicare health plans.

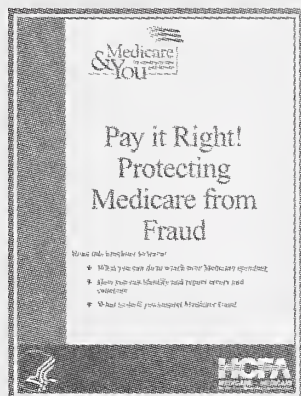
Available in English (HCFA Pub. No. 10119), and Spanish (HCFA Pub. No. 10119-S).

Coming Soon!

Medigap Policies

This brochure provides basic information about Medigap policies which supplement the Original Medicare Plan.

Available in English (HCFA Pub. No. 10139), and Spanish (HCFA Pub. No. 10139-S).



Pay it Right! Protecting Medicare from Fraud

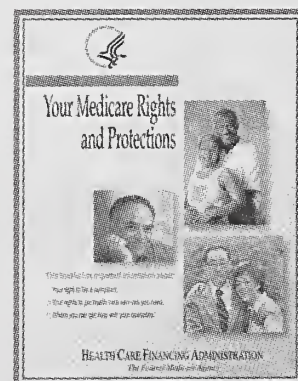
Each year, fraud causes Medicare expenses to grow! Learn how to spot warning signs of fraud and how to report errors and concerns. Also learn how to protect yourself and the Medicare program. It includes a list of tips to prevent fraud.

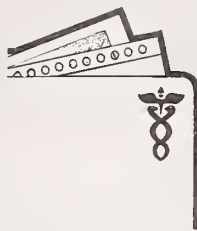
Available in English (HCFA Pub. No. 10111), Spanish (HCFA Pub. No. 10111-S), and Chinese.

Your Medicare Rights and Protections

Lists your Medicare rights and protections in the Original Medicare Plan and other Medicare health plans as well.

Available in English (HCFA Pub. No. 10112), Spanish (HCFA Pub. No. 10112-S), and Chinese (HCFA Pub. No. 10112-C).



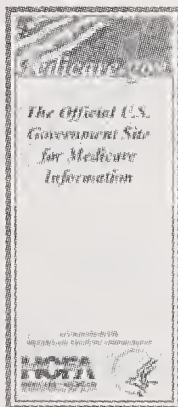
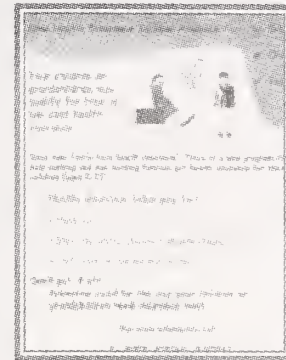


Other Medicare Publications

New Health Insurance Now Available for Infants, Children, and Teens

This is a fact sheet on the State Children's Health Insurance Program, a program to help provide free health coverage for uninsured children.

Available in English (HCFA Pub. No. 10135), and Spanish (HCFA Pub. No. 10135-S).



Medicare.gov

This brochure has useful information about HCFA's website www.medicare.gov. It includes information on HCFA's many comparison databases, including Medicare Health Plan Compare, Nursing Home Compare, Helpful Contacts, and more!

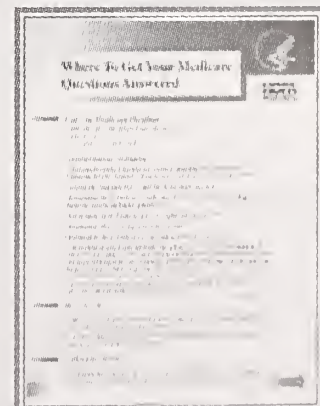
Available in English (HCFA Pub. No. 10108), and Spanish (HCFA Pub. No. 10108-S).

Where To Get Your Medicare Questions Answered

NEW!

This fact sheet explains who you should call to get your Medicare questions answered. When should you call the Medicare helpline? When should you call the Social Security Administration?

Available in English (HCFA Pub. No. 02246), and Spanish (HCFA Pub. No. 02246-S).



**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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NOTE:

- At the time of printing, the titles listed were correct. Booklets are revised and updated throughout the year, and new booklets may become available. The publication number always stays the same.
- For the most up-to-date list of publications, visit www.medicare.gov on the Web. Select "Publications."
- To get a copy of this catalog in Spanish, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).
- ¿Necesita usted una copia de esta publicación en español? Llame gratis al 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 para personas con impedimentos auditivos o del lenguaje oral).

NATIONAL MEDICARE EDUCATION PROGRAM

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UPDATED JULY 2001

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These publications provide general information on Medicare:

Medicare & You 2002

2001 Guide to Health Insurance

Where to Get your Medicare Questions Answered

Rights and Protections

Need more information? Also included in this edition are:

Medicare Savings Programs, for help paying health insurance costs

Health Insurance for Infants, Children, and Teens, for options currently available

Home Health Care, for details on who's eligible and how to find a home health agency

Medicare Preventive Services, to learn more about services Medicare covers to help you stay healthy

www.medicare.gov, to find out what's available on the official Medicare website

New Rules for Switching Medicare Health Plans, for important information for people in or thinking about joining Medicare managed care or private fee for service plans

Publication Catalog, for free booklets on Medicare and related topics





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CENTERS FOR MEDICARE & MEDICAID SERVICES
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